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What the People of Michigan Think of Medicine

By John F. Hunt
Chicago, Illinois

■ Dr. Novy has just told you that you, in the person of the Michigan Health Council, have caused an examination to be made of the collective mind of Michigan on the subject of medicine. He has told you that tonight we are going to give you the results of that survey—that we are going to tell you "What the People of Michigan Think of Medicine."

That we are going to do, but first I would like to make a few preliminary remarks.

I would like to tell you that we are not in the business of making surveys because we *love* making surveys. We would stop making surveys tomorrow if they were not vital to our real business which bluntly is making the 130,000,000 people of this country think the way our clients want them to think.

We know, and we know unfailingly, that we can't do that successfully unless we first find out what is already in the minds of these 130,000,000 people. We have to *know* with certainty not only what these people are thinking but what their real interests are—what they want—what they don't want.

The combined annual advertising expenditure of our clients exceeds $30,000,000. With this large expenditure at stake—with the profits of the important businesses it represents, at stake—firms like American Tobacco, Armour, Lockheed, New York Central, Frigidaire, and a score of others equally prominent in their fields, we can't afford to base our recommendations on guess or gamble. We need *Facts*. We can no more write a sound business prescription without facts than *you* can write a sound medical prescription without complete knowledge of your patient's condition.

What do *you* do to arrive at *your* diagnosis?

You put a stethoscope on him—you may use a fluoroscope—you may decide you need some x-rays—you try for a knee reflex—you do a host of things, but the principal basis of your diagnosis in the average case is the answers you get to the questions you ask. *You ask questions.*

That's what we do, too. We know that the only way to accurately diagnose the thinking of 130,000,000 people or the 5,000,000 people of Michigan, is to go to the people *and ask questions.*

Obviously, it's impossible to interview 5,000,000 people. Nor is it necessary, for just as you in medical research find a pattern forming in the treatment of a given number of cases—so do we in our kind of research. The principle that the mass opinion can be accurately established by

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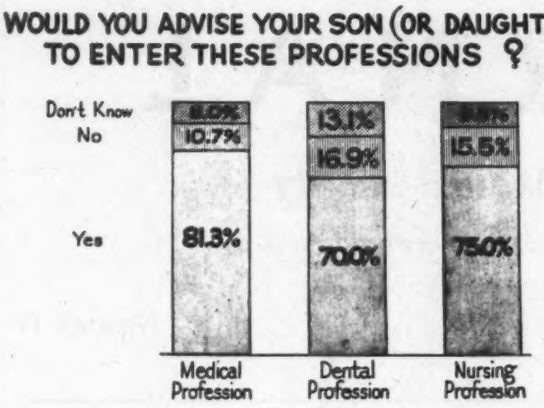

Chart 1

a study of a relatively small number of people properly selected, is completely accepted by all authorities on psychological research.

The accuracy of this kind of research—the sampling method—is being proved commercially by hundreds of cases every year. Perhaps some of you in the medical profession have had no occasion to see or study them. I am sure, however, that all of you are aware of the remarkable record for accuracy that has been turned in, in the last ten years by practically every political poll conducted with a *truly representative cross section* of a state of the nation.

This same sampling method was used to ascertain what "The People of Michigan Think of Medicine."

Across and up and down the state we sent trained investigators to talk personally to a large and properly selected cross section of the whole state of Michigan—more than enough to ascertain accurately what your 5,000,000 citizens think of your profession. These investigators talked personally to approximately 5,000 people representing every class of person able to form an opinion. They spent more than an hour with each of these 5,000 people. They asked twenty-eight basis questions. Out of these twenty-eight questions came 162 cross tables which reveal almost all aspects—certainly the most important aspects—of the opinion of your entire population about medicine and its practice in the state of Michigan.

For the purpose of this presentation and within the limits of the time available, these are the most significant facts:

Chart 1 is self-explanatory. It shows immediately that the people of Michigan are people with opinions. Their opinion on this question is, as perhaps you might expect it to be. Eighty-one per cent would *definitely* advise their son to enter your profession. Those of you particularly who have grown sons know that parents do not lightly consider the question of what career is best for their children. Consequently, you may rightly conclude that the people of this state consider yours as a *fine* profession.

This high estimate of the medical profession is emphasized by the fact that 70 per cent, or 11 per cent less, would advise their sons to enter the dental profession. Even the nursing profession which has always been held in great esteem by the American public did not pull as favorable a vote as a career for the daughters of Michigan.

Among those who had negative opinions of these three professions, there are fewer people who have objections to the medical profession

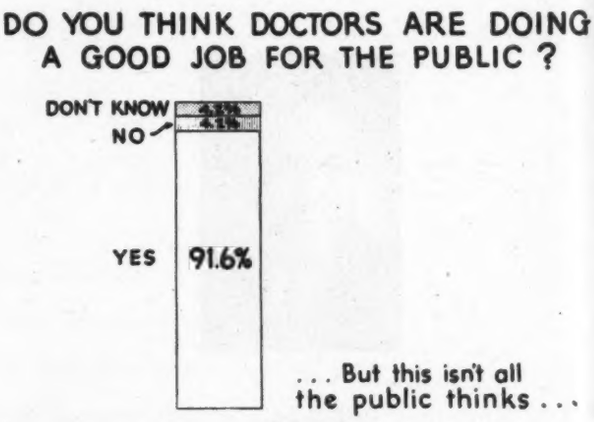

Chart 2

as a career for young people than they had to the two others under question. The principal cause for their negative votes was the fact that it was a hard, difficult life to lead. Particularly after the last couple of years you doctors know what these people had in mind.

The high favor which is evidenced in their responses to this question should be very gratifying to you. However, this next chart will kindle your inner glow ever brighter.

More orchids! And deservedly so. The people of Michigan think you are doing a grand job—and they tell you so in no uncertain terms in their answer to this question (Chart 2). Only 4 per cent have failed to make up their minds. Another 4 per cent of the total have generally decided that you are bad medicine. But 91.6 per cent think you rate a big vote of confidence. Even "The

Indispensable Man" never got a popular vote like that. But this isn't all the public thinks—and remember they *THINK*—and eventually they *ACT*. Here's the first danger signal.

Chart 3 shows that 61 per cent of the people of Michigan think your profession and you doctors in it are honest. 11.2 per cent have no opinion, but despite the fact that as we have just seen on the preceding chart, 92 per cent are willing to give you a Distinguished Service Medal, 28 per cent think you are *not honest*.

You may be interested in the breakdown of that 28 per cent. Here it is: Forty-one per cent of the 28 per cent think you do not give all the facts or tell the truth. Another 18.2 per cent think you overcharge. Fourteen and a half per cent believe you prescribe too many unnecessary treatments.

You may say, "That isn't so bad—not many of

DO YOU BELIEVE DOCTORS ARE AS HONEST AS THEY SHOULD BE IN ALL DEALINGS WITH PATIENTS?

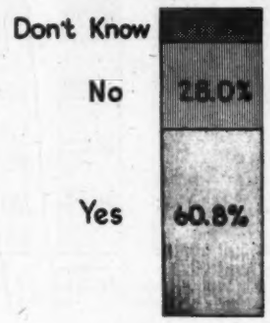

Chart 3

them think we're actually dishonest," but *it is bad*. It doesn't make any difference what their reasons are, the fact remains that 28 per cent of the people of Michigan believe the medical profession is *not as honest as it should be*. You also may say, "They probably think other professions (including the advertising business) are *far less honest*." That doesn't make any difference either. It's *your* business that's being threatened by Senate Bill No. 1161.

Here we begin to really examine the Michigan mind about their attitude on the import of No. S-1161, the Murray-Wagner-Dingle Bill (Chart 4). We find the people of Michigan less inclined to favor government control in medicine than do the people of the nation at large. While this is a bit more encouraging than the national picture, the fact that 39 per cent of the people of

DO YOU THINK WE SHOULD HAVE SOME SORT OF A GOVERNMENT OPERATED MEDICAL-HOSPITAL PLAN?

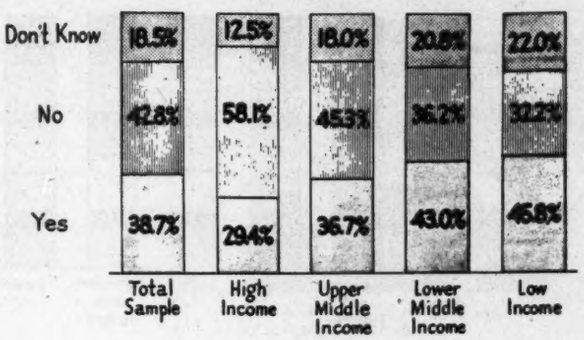

Chart 4

Michigan are already favorable to government-controlled medicine should be an exceedingly disturbing fact to you. When you add the 18.5 per cent who have not made up their minds, but who could be swayed either way, you should immediately see how dangerous this situation can be. By some manner or means you must win over slightly better than 61 per cent of these uncertain people—merely to be—*just on the safe side*.

As you might suppose, the percentage of those in favor of government control increases as you reach the lower income brackets. These are the people who are most easily swayed by the arguments of the surface-thinking, or surface-expounding, proponents of government control of medicine. These are the people, by and large, who from 1932 on for the next solid seven years were the principal beneficiaries of the largesse distributed by those who are now behind the proposal to take the control of medicine out of your hands ostensibly to put it into the hands of the people.

Here is another breakdown of this opinion which will be a constant threat to your profession until you do something more than argue defensively about it.

The only sweet note in this picture (Chart 5) is that the farmer, who has always been a rugged individualist, is less favorable to government control than are the professional, executive, clerical, white-collar class of worker. However, again you find that even in the farm population, a substantial group have not as yet made up their minds. Remember, too, that despite their customary attitude of independence, they as a class have been the recipients of a large and generous

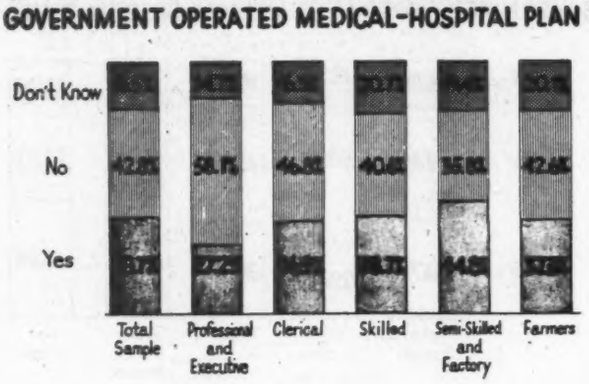

Chart 5

measure of government bounty. The farm block is always a strong and militant group which will continue to fight for special farm benefits. You know Washington as well as I do. You know the trading that goes on there. You know in principle that when you get things you have to give things. I don't know, and you don't know, whether the farmer would be willing to sacrifice his opinion on a question like this for a 10-cent higher ceiling price on a bushel of wheat or not. But you know, and I know, it's easier to give away something which you are uncertain you want than it is to sacrifice a princple or a system which you have definitely decided is right and desirable. By some manner or means the medical profession must *fix* in this 20 per cent of the farm mind, the conviction that government control of medicine will be as harmful to their best interests as you know it is to yours.

The import of Chart 6 is very clear. The two age groups—sixteen to twenty-four and twenty-five to thirty-four—are more in favor of government control than are the age groups thirty-five to forty-four and forty-five and over. These young people have grown up under the influence of a social program which began to be promulgated some twelve years ago in Washington. They have been more subjected to socialized thinking than have the older groups whose opinions and convictions were formulated under a different regime. Thus we have an added significance in this for you and your profession, because you are not only concerned with conditions as they exist today, but as they may exist five, ten, twenty years from today. The older groups shown on this chart as being less favorable to government control of medicine are those who will be the first to pass from the scene where opinion or a vote has significance. One of your jobs will be to build a back-fire to serve as a brake on the increased adoption by the younger people of that kind of theory which is inimical at its base to your desire to have the control of your business in your own hands.

Here is another angle on the attitude of people regarding the control of medicine (Chart 7). This angle is favorable to your side of the debate.

The left three bars were the chart which opened this presentation. The findings are repeated here so that you can compare them directly with the findings on this same question when these professions were hypothetically put under government control. The changed attitude of the Michigan public is immediately apparent. Of the 81 per cent who had said they would urge their children to enter these professions 45 per cent

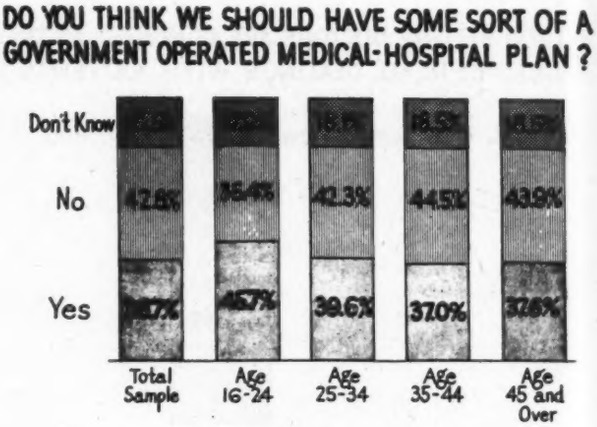

Chart 6

immediately changed their minds when we asked them if they would still so advise their children if these professions were under government control. The percentage of those who would veto this kind of a career for their children has increased almost three-fold. The percentage of those who have as yet arrived at no opinion on this question of a medical career under government control, has increased at least two and one-half times.

In our opinion, this constitutes one of the strongest indictments of government control of medicine and should be a very potent argument against it, particularly, if you win over the 19.6 per cent who as yet have no fixed opinion. The combination of these two groups would at least give you a clear majority. I personally would view with great alarm the future of medicine in

this country if it were established that the majority of our fathers and mothers were against having their sons and daughters enter the medical profession.

This question (Chart 8) gave the people a *choice* of five different ways of securing medical care. We have also incorporated in the bottom portion of this chart their votes when they were *not* given a choice but were merely asked, "Do you think we should have some sort of a government-operated medical-hospital plan?" The difference in their attitude under these two different conditions is immediately clear; whereas 38.7 per cent of all the people voted for a government plan when they were given no alternative except the present system, only 15.5 per cent of all the people voted for government control when they were given a choice of these *five* ways of securing medical-hospital care. Thirteen

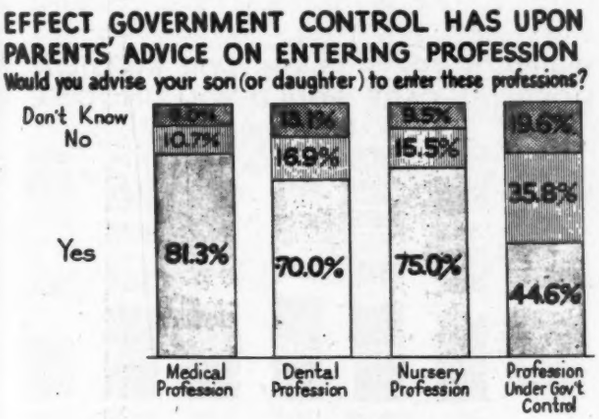

Chart 7

and four-tenths per cent would choose a plan offered by an insurance company; 26.6 per cent said they would stick to the present system.

An indication of great significance is the fact that 33.7 per cent of all the people, by far the greatest number, when given a choice, selected as most desirable a voluntary prepayment plan sponsored by the medical profession.

More significant still is the actual breakdown of the preference of the 38.7 per cent who had favored government control when they were offered a *choice* of securing medical care. Almost two-thirds of them desert government control in favor of other methods. Where do they go? One and one-tenth per cent choose a union plan. Twelve and four-tenths per cent feel they would be better off with the insurance companies. Fourteen and 8-tenths per cent choose the present system. The largest block, 26.8 per cent., of those who had voted for governmental control, prefer a professionally controlled prepayment plan *when offered a choice.* It shows further on the third bar that when given a choice those who had already expressed themselves as being *negative on government control* are more fixed in their opinions than those who had expressed themselves as being *in favor of government control.* Thirty-six per cent of this class would favor the present system and only six-tenths of 1 per cent would be satisfied to have medicine dispensed by government-controlled doctors.

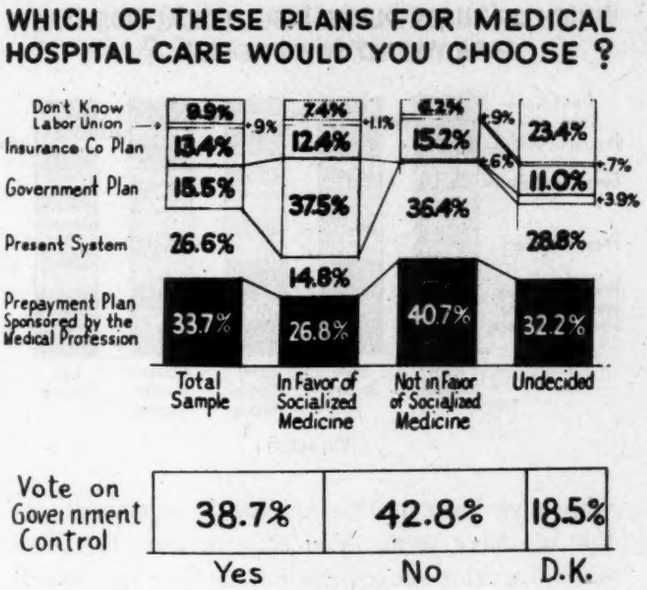

Chart 8

It also shows that given a choice of these five plans, only 3.9 per cent of the undecided ones would favor government-controlled medicine. Again, we have the important factor of those who still have not made up their minds. If you can influence *favorably* the still undecided ones, the 23.4 per cent who *still* cannot make up their minds when offered a choice of these five plans, you will bring better than 50 per cent of the undecided 18.5 per cent votes, shown in the bottom horizontal bar, into your column. This would certainly be a step in the right direction.

We should not leave this chart without making another important observation. In a preceding chart and in its repetition here in the horizontal bar, it shows that only 39 per cent of the population of your state have voiced their opinion as being in favor of government-controlled medicine.

This is quite a bit below the number of people

WHICH OF THESE PLANS FOR MEDICAL-HOSPITAL CARE WOULD YOU PREFER ?

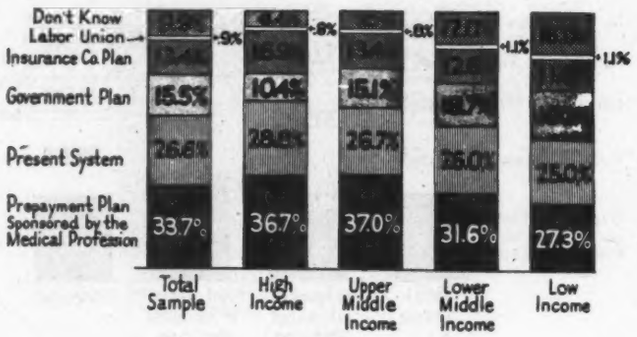

Chart 9

who have been of this opinion in other surveys that we have seen. You all remember the Fortune Magazine survey made some time ago, which showed that 74.3 per cent of our 130-odd million people were in favor of government-provided medical care through the collection of taxes. The answer to this question in any survey, of course, depends largely on the way the question is asked. It is one thing to ask average persons whether they would be in favor of government-supplied medicine for all the people, and quite another thing to ask them if they think the government should control medicine through a tax imposed upon its citizens. Practically all of the surveys that we have seen which have interrogated the people without weighting the question have shown responses favorable to government control in larger measure than the vote it received in Michigan. We ourselves conducted a similar survey in the State of California. It was delivered to the California Medical Association in January of this year and showed that 50 per cent of the people of California were in favor of government-controlled medicine, in contrast to 39 per cent for Michigan.

We believe that the activity of the Michigan Hospital Service and the Michigan Medical Service in this state has been largely responsible for the smaller number of people here who are willing to endorse medicine under government control.

Examining the state of Michigan further on these five different ways of securing medical-hospital care (Chart 9), we find that the high income and upper income brackets are more in favor of pre-payment plans sponsored by the medical profession than are the low middle income or the low income groups. This is, again, as you yourselves might have predicted.

There is a remarkable consistency in that portion of the total sample in all income groups that indicated they were perfectly satisfied with the present system of dispensing medicine.

This chart offers additional evidence that a plan of *government-controlled medicine becomes more and more appealing as income levels descend.* Corollary to this, the insurance plan becomes more attractive as you ascend from the lowest income to the highest income levels.

Also, as you yourselves probably would have anticipated, the lower you descend by income levels, the higher becomes that portion of the public which is unable to choose between these five ways of securing medical care. If you compare the "don't know" figures, however, with chart No. 4 in which we showed you that 20.8 per

WHICH OF THESE PLANS FOR MEDICAL-HOSPITAL CARE WOULD YOU CHOOSE ?

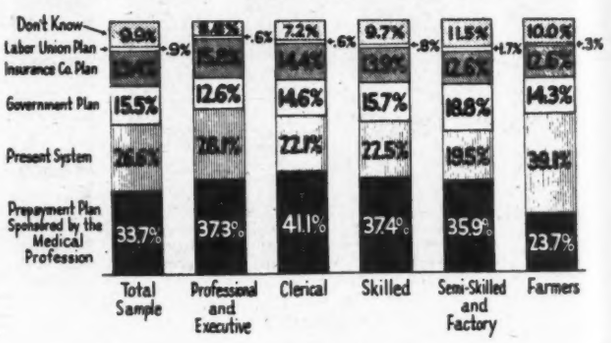

Chart 10

cent of the lower middle income group and 22 per cent of the low income group were unable to make up their minds about the desirability of government-controlled medicine, you will immediately see that given a *choice* of plans for medical-hospital care these people find themselves far more able to decide which is preferable.

By occupational groups the government plan is shown to peak in favor as you progress from group to group until you come up against the rugged individualism which has always characterized the American farmer (Chart 10).

The really encouraging significance from this chart is that given *a chance to choose,* even the semi-skilled and factory class who have been shown to be most in favor of government-con-

trolled medicine now register a 55.4 per cent vote for medical and hospital care dispensed by doctors of their own choice.

We have said before in this presentation it was our opinion that the activities of the Michigan Medical Service and the Michigan Hospital Service were largely responsible for the fact that fewer people in Michigan were in favor of government-controlled medicine than is true nationally. Chart 11, also, shows your efforts to date in this state have certainly been effective. When you consider the fact that only 34.9 per cent of the people of Michigan say they have heard of the Hospital Service Plan and yet remember that 23 per cent are already enrolled in Michigan Hospital Service, it seems to me to indicate an exceptionally high degree of conversion or sales performance. When you consider further that 23.8 per cent of the population say they have heard of the Medical Service Plan, and you know that 13.5 per cent of your population is enrolled in the Michigan Medical Service, it indicates that here, too, a truly remarkable conversion job has been done. Also, it indicates that the cause of medicine in Michigan will be further served, and greatly served, if the educational and promotional efforts of these two organizations are solidly supported by the whole profession extended and extended rapidly.

HAVE YOU EVER HEARD OF THE BLUE CROSS PLAN, MEDICAL SERVICE PLAN, HOSPITAL SERVICE PLAN?

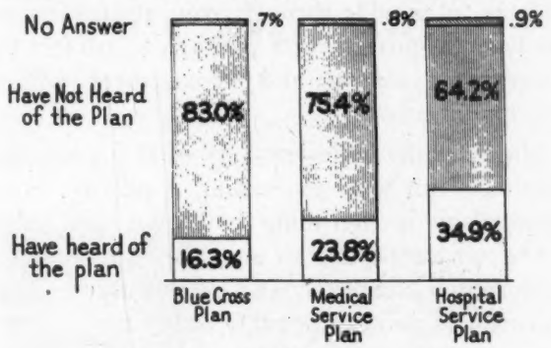

Chart 11

The *popularity* of the medical-hospital plan in Michigan under professional control and *not under the control of government* is amply evidenced by Chart 12. Seventy-nine per cent of the people to whom a plan of this kind was available have accepted it. This is a higher percentage than the very highest that I have ever seen as given for people favoring medicine controlled by the federal government. I would refer you back to the Fortune survey, which gave at that time that seventy-four per cent of the people were in favor of government-dominated medicine.

IS THE MEDICAL-HOSPITAL PLAN AVAILABLE TO EMPLOYEES WHERE YOU WORK?

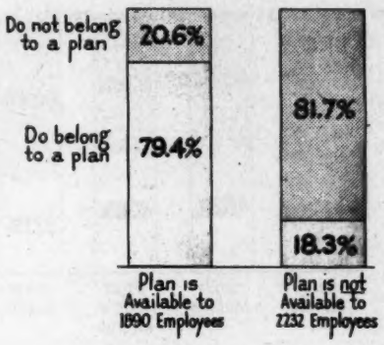

Chart 12

A further significance of this chart is the fact that a medical-hospital plan is not yet available to 45.5 per cent of the people of Michigan at their place of employment.

This is indicated by the fact that out of our total sample of nearly 5,000 people, there were 2,232 employes who were not able to secure group medical-hospital care at their place of employment.

Another fact that is not shown in this chart is that 16.2 per cent of the people interviewed did not know whether such a plan was available to them or not.

This is just another measurement of the educational and promotional job that lies ahead of you if you are to use every means at your command to successfully prevent the one thing I am sure everybody in this room does not want to see happen to the medical profession—and I am not talking about losing your stethoscope.

Chart 13 is further evidence of the remarkable success of those who have promoted medical and hospital care under voluntary control and operation. Forty-two per cent of Michigan's families have one or more members who are already enrolled in some type of medical or hospital plan of their own choosing. This ranges from a low of 27.9 per cent in the lowest income groups to a high of 49.3 per cent in the highest income groups.

DO YOU OR ANY MEMBERS OF YOUR FAMILY BELONG TO A MEDICAL OR HOSPITAL PLAN ?

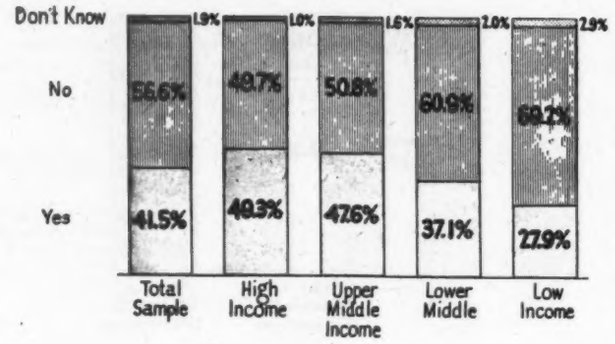

Chart 13

This also indicates that you should throw the greatest weight of your educational and promotional efforts against the lower incomes. Why? Because throughout this investigation they have shown the lowest acceptance of voluntary medical and hospital care. Because it is common knowledge that they are more susceptible than any other class to the principle of government control over anything—including the practice of medicine.

As I said at the beginning, we confined our attention in this presentation to those facts developed by the survey which we felt to be most interesting to this audience. In the complete job there are shown a great many additional facets of the complete Michigan thinking on both medical and hospital care. I don't know what distribution the Michigan Health Council is going to make of the bound copies of this investigation, but I would urge all of you to spend some time studying the other things which we have not had time to present here tonight.

Before I finish I would like to make several observations. I believe that this presentation has given you added confirmation of the dangers that actually confront your profession. The fact that the people of this sovereign state are less inclined than are the people of the nation as a whole to literally junk the fine work that they and all the other people of this nation say you have done and are doing, should not dull the edge of your fervor to protect the practice of medicine as you want it practiced. Unless you remain militant—and I don't mean argumentative—you may see, maybe not this year, maybe not next year, but ultimately you may see, regardless of Michigan's attitude, the threat that is now confronting medicine turn into an actuality.

You have seen in this presentation that the people of Michigan have some reservations on your profession. Certainly, to correct these impressions should be one of your first activities. I don't mean that you should persuade the public that they are wrong in their reservations about the practice of medicine. I mean that you should correct the things that lead them to this opinion. If it is necessary to police your profession to make certain that the Michigan public have no cause for thinking that your profession is dishonest, you should police it.

You should support, and actively support, any movement within your state which will begin to supply a perfect medical-hospital package for all the people of this state. The only way that you or your profession nationally can successfully combat the threat of government-controlled medicine is to provide through your profession and the hospital profession a package so perfect that government control and management will be clearly unnecessary.

Maybe I had better explain what I mean by a "package" for your profession. A package in our terminology is the thing you offer the public. To be most appealing to your public it should be as close to a completely and beautifully wrapped-up entity as you can possibly make it.

Senate Bill No. 1161 proposes such a "package"—a medical-hospital package for the people. You in your voluntary medical-hospital plans also have a package to offer.

Isn't it obvious that you are theoretically in competition with the package Senate Bill No. 1161 proposed? That being the case, you must make yours as complete, as appealing, as your competitor's, or you lose the sale.

The benefits you offer the people must be broadened to meet your proposed government competition. You must find a way through professionally controlled medicine and hospitalization to take care of all the people if you want these people to buy *yours* instead of the package numbered 1161.

If you immediately begin in a concerted manner to devote all of your available energies toward really winning this battle, the price paid for this survey will be a good investment. If you are lethargic about any possible activities that

may conceivably make this state safe for medical and hospital care professionally controlled, if you are complacent about what is going on in the rest of these United States of ours, then the price paid for this investigation automatically becomes a very poor investment.

I might even say—if the facts revealed by this investigation fail to spur you to ultimate effort in perfecting what you have here in Michigan—if they fail to make you just as active in fighting for and providing your kind of medicine on the national stage, the money spent for this investigation will not only be *wasted,* but your profession as you know it and as you want it—may ultimately be *laid* waste as well.

MSMS

Primary Atypical Pneumonia

By A. A. Applebaum, M.D.

and

C. E. Hufford, M.D.
Toledo, Ohio

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Since primary atypical pneumonia has only in recent years been described, and is so commonly seen, a review of the subject is quite timely. It has become a serious problem in civilian life, as well as in the Armed Forces. This condition is, perhaps better known as "virus pneumonia," although no virus has been definitely isolated as the etiologic agent. The predominant features are the relative scarcity of physical signs and failure to respond to sulfonamides and penicillin. A clinical study of 165 cases will be given, including one case report with post mortem findings. The discussion will include a survey of the etiology and epidemiology of the condition, the clinical features, diagnosis including the roentgenologic characteristics, pathologic findings, and treatment.

PRIMARY atypical pneumonia has received increasing attention as a disease entity within the last five years. It may be defined as a clinical syndrome which is characterized by an influenzal-like onset, patchy pneumonic signs, relatively normal white and differential blood counts, absence of any obvious bacterial etiology, definite roentgen findings of a patchy infiltration, and the failure to respond to the modern forms of chemotherapy in a satisfactory manner.

This is not a new disease as Owen[24] in his review pointed out that a similar pneumonia existed as early as the nineteenth century, which resembled the present form of primary atypical pneumonia. However, within recent years atypical pneumonia is appearing with great frequency, not only in civilian life, but especially in the armed forces where thousands of cases have been observed. In most hospitals and camps, it is appearing in far greater frequency than is lobar pneumonia. In Ford Hospital[15] from 1938 to 1941, atypical virus pneumonia was seen once to each six cases of pneumococcic pneumonia; and in 1942, there was a ratio of six cases of primary atypical pneumonia to every seven cases of pneumococcic pneumonia. In a recent report from the Station Hospital at Jefferson Barracks, Missouri, 1,862 cases of atypical pneumonia were reported in a fourteen-month period, June, 1942, to August, 1943, as contrasted with 62 cases of pneumococcic pneumonia for the same period at the camp.[33]

This disease entity has been referred to by many names, such as acute pneumonitis[2], broncopneumonia of unknown etiology[19], atypical bronchopneumonia with leukopenia[21], acute interstitial pneumonitis[30], disseminated focal pneumonia[9], virus pneumonia[22], and atypical pneumonia[5]. In March, 1942, the official military nomenclature was changed to primary atypical pneumonia, etiology unknown[26]. For convenience, this has been shortened to atypical virus pneumonia, or just atypical pneumonia[8]. No doubt the name "primary atypical pneumonia, etiology unknown" is best at present until the time comes when the etiologic agent is definitely described.

Etiology

Attempts at isolation of a definite etiologic agent have been for the most part unsuccessful. No known bacteria have been shown to be consistently present or to show any definite relationship to the disease. There has been a widespread lack of susceptibility of the usual experimental animals for the etiologic agent, if it be a single agent. It is interesting to note that ferrets, though susceptible to the influenza virus, are

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resistent to the agent of primary atypical pneumonia[13,31].

Numerous etiologic studies have been carried out. Francis and Magill[13] and Stokes, Kenney, and Shaw[31] recovered a filterable agent from the nose and throat washings of those who had the disease, but lost the agent after a few animal passages before it could be identified or proved. From four cases of primary atypical pneumonia Weir and Horsfall[34] isolated a filterable virus which produced lung consolidation in the mongoose. It was shown that contact mongooses developed the disease from infected ones and that convalescent mongoose serum protected against the disease or neutralized it, while normal mongoose serum did not. However, their results are somewhat inconclusive because of the failure to increase the virulence by serial animal passages and the resistance of some of their laboratory animals to infection.

Eaton, Back, and Pearson[11] isolated a virus similar to the virus of psittacosis. Favour[12] in his virus studies has shown the relationship between primary atypical pneumonia and ornithosis. Baker[3] has described an atypical pneumonia in cats which was also apparently contagious for man. On transmission to laboratory animals elementary bodies similar to psittacosis were found. Rake, Eaton, and Shaffer[27] have shown the similarities existing among the viruses of psittacosis, meningo pneumonitis, and lymphogranuloma venereum. Reiman[28] has an explanation which helps show the relationship and value of these virus studies. He has demonstrated that the viruses of psittacosis, of psittacosis-like infections, of chorio-meningitis, and of lymphogranuloma venereum cause meningitis, pneumonia, and skin granuloma, which are indistinguishable. Serum from numerous patients with primary atypical pneumonia fixed the antigens of these diseases. The Frei test was found to be positive in some cases of primary atypical pneumonia. This suggests that the viruses have a common origin in a parent strain, probably residing in birds or animals, which has become diversified by passage and adaptive residence in different hosts and tissues.

Other studies concerning the etiological agent are continuing. Dyer, Tapping, and Bengston[10] were able to isolate the rickettsia of Q fever in several cases of atypical pneumonia. However, to date, there have been no bacteria, no rickettsia, nor virus isolated which has been shown to be the cause of this type of pneumonia.

Epidemiology

Primary atypical pneumonia may occur in endemic or epidemic form. The widespread distribution must be due to the large number of unrecognized subclinical cases which are not apparent. The agent or agents producing this disease may set up a constitutional reaction of varying degrees of severity both with and without obvious chest signs. Careful studies have failed to reveal the existence of a nonhuman reservoir such as milk, water, ticks, chiggers, flies, and mosquitoes; obviously, the source of infection is contact with infected humans. While primary atypical pneumonia does not appear to be highly contagious, prolonged exposure and contact, such as occurs in hospitals, military barracks, and college dormitories, results in a high incidence of this disease. Although there is a sporadic occurence throughout the year, this type of pneumonia is more prevelant between the months of September to March. The literature reveals that the accepted incubation period is usually between one to three weeks, most likely about twelve to fourteen days. In our series, we found one case with an incubation period of four days, which is unusual.

Pathology

The gross and microscopic pathology of atypical pneumonia is rather definite, although the material for such observations is most scant since a patient rarely dies from this disease. Up to March, 1944, thirty-one autopsies from atypical pneumonia have been reported including nine fatal cases in infants described by Adams.[1,24]

The pathological changes described up to the present time have been very much the same with the exception of the cytoplasmic inclusion bodies in the bronchial epithelium reported by Adams and Saphir.[1,29] Reiman[28] has shown these inclusion bodies can be produced by hemophilus pertussis, tularemia, toxoplasma, toxins, and irritant chemicals.

The pathological changes found in the lungs consist of a patchy consolidation with areas of emphysema between small confluent areas of bronchopneumonia. There is inflammation along the entire respiratory tract including the minutest bronchioles. Bacteria are extremely few in number. Microscopically, the involved areas of the

lungs show congestion and infiltration of the alveolar walls with monocytes, lymphocytes, and occasional neutrophiles. A similar reaction is present in the peribronchial and perivascular tissues. Many alveoli contain numerous large actively phagocytic monocytes, some eosinophiles, scant neutrophiles, fibrin, edema fluid, and red blood cells. Varying stages of the disease are seen including a tendency toward fibroblastic proliferation. Splenitis is usually present; there also may be an arteritis present in the lungs with thrombus formation. These pulmonary lesions are not pathognomonic of primary atypical pneumonia since similar changes are found in other interstitial pneumonias of known etiology.[14]

Clinical Picture

As was first described by Kneeland and Smetana[18] our cases fell into three groups on the basis of severity. The first group, comprising 75 per cent of our cases, is known as the mild type. 15 per cent of our cases were of the second group or severe form which involved large amounts of lung tissue and the patients were critically ill. The remaining 10 per cent composed the third group, or migratory type, which spread from one lung area to another, lasting for several weeks.

Our clinical study is based on 152 cases all verified by positive roentgen findings. In general, the onset of the disease was influenza-like with a sore throat, severe protracted headaches, chilliness, generalized aching, drenching sweats, severe cough in paroxysms, which, at first, was usually nonproductice. Sputum was rarely rusty or bloody, usually scant, but often produced in increasing amounts as the disease progressed. Fever ranged between 99°F. to 104°F. The pulse was relatively slow in proportion to the fever, and prostration was not great in the mild type of this illness. Pleuritic pain seldom was encountered; however, the cough was so severe that retrosternal soreness which was not related to respiration was common. Only those who were classified as the severe type demonstrated signs of toxicity with cyanosis, tachycardia, and dyspnea. Although abdominal distension was rare, soreness of the abdominal muscles due to coughing was extremely common.

The physical signs were few. Usually the patient was only moderately ill, conjunctival injection was present, and pharyngeal inflammation was slight. Physical signs in the chest were usually absent or very scant. In 30 per cent of our cases only a suppression of breath sounds or an unusual type of dry crackling rales heard at the end of inspiration were present early in the course of the illness. Yet nearly 70 per cent of our cases which showed no positive chest findings on physical examination early in the disease showed definite areas of a patchy consolidation on roentgen examination. By the time the fever, which usually lasted three to seven days in the mild cases, subsided, the physical signs of consolidation of a patchy type became evident. These signs persisted in the severe cases for several weeks. The disease usually ran its course in ten days to three weeks, though it was shorter in the mild cases and greatly prolonged in the severely ill patients.

Roentgen Findings of Atypical Pneumonia

The diagnosis of atypical pneumonia depends upon the clinical picture with associated roentgen findings. We are convinced that in no case could a diagnosis be made on either the clinical course or the roentgen findings alone. The information gained from roentgen examination is the deciding factor in arriving at the diagnosis. Most frequently there are thickened hilar shadows, usually one hilus showing more increase of density than the other. The thickening extends out from the hilus and is peribronchial in distribution resulting in accentuated lung markings. The distribution of the thickening in the early state is usually irregular and is not limited to one portion of a lobe, but is scattered and diffuse. There are diffuse patchy densities extending out from the hilus. Subsequent changes follow rapidly and localized areas of pneumonitis are seen which are fairly sharply defined, though their margins are feathery and hazy. The pneumonic infiltrations may be confluent or homogeneous, yet large areas of consolidation are not common. The lung markings are usually seen through the consolidation and give a characteristic striated appearance. The areas of increased density are most likely small lobular forms of atelectasis produced by blocking of the bronchi and bronchioles with exudate and swollen epithelium.

If the involvements are sufficiently extensive and confined to one lobe, the appearance is similar to lobar pneumonia. Likewise, there may be an associated thickening of the visceral pleura over the involved lobe similar to that found in

lobar pneumonia. In a small percentage of cases the involvement may be limited to the upper lobes and the resemblance to tuberculosis may be striking. In these cases repeated examination with serial films are required for a definite diagnosis.

The distribution of involvement may be central, confined to one or both lower lobes, or one or both upper lobes. Not uncommonly a single or multiple type of lesion progresses satisfactorily with clearing of the infiltration, but with little clinical improvement. Nevertheless, a subsequent film may show entirely new areas of invasion similar in all respects to the first involvement. In some cases, resolution may begin as early as the third day and in other cases extend beyond three weeks.

Laboratory Findings

The Laboratory data were of value in differentiating this disease from bacterial pneumonias. The white blood count in primary atypical pneumonia was relatively normal, being for the most part slightly above or below 7,000. The differential counts were also within normal range in most cases. In about one-half of the cases pneumococcus typing was done and in all instances failed to show the presence of pneumococci in the sputum. In two of our cases a search was made for agglutinins in the urine without success. Within the last year and a half, it has been demonstrated that the serum from patients with severe primary atypical pneumonia contained "cold agglutinins." This agglutination appeared several days after the onset of the febrile period, increased as the disease progressed, declined as the patient recovered, and eventually disappeared. The rarity of cold agglutinins in bacterial pneumonias and other diseases may make this test an important aid in identifying some of the cases of atypical pneumonia.[25] In those cases of our series in which sedimentation tests were done, 60 per cent showed an elevation of the sedimentation rate during the active process and a gradual return to normal as the disease subsided.

Complications

In our series of cases 29 per cent of the patients developed complications in the course of their illness. In the 1,862 cases at Jefferson Barracks, Missouri, previously mentioned, 36.2 per cent of those cases developed complications.[23] In our group, the most common complication was a reactivation of the pneumonic process which occurred in 10 per cent of the cases. Recurrences are infrequently mentioned in the literature and only one of our patients developed a recurrence one year after the original illness. In numerous reports, mention is made of the neurologic complications. Six of our patients developed an encephalitic picture characterized by severe headache, delirium, stupor, confusion, and neck rigidity. Other complications included eight patients who developed dermatitis medicamentosa due to sulfonamide therapy; one case of agranulocytosis due to sulfonamides; a case of acute nephritis due to sulfonamides; three cases of severe stomatitis and pharyngitis; one case of acute tonsillitis; three cases of severe asthma; seven patients had extreme respiratory distress, five requiring the use of oxygen and two the use of helium and oxygen; and one case of the Stephens-Johnson syndrome (conjunctivitis, stomatitis, and atypical pneumonia) which was further complicated by an encephalitic picture. No pleural effusions nor empyemas occurred. In the entire series of 152 cases, there were three deaths (one autospy obtained) with a mortality rate of approximately 2 per cent.

Differential Diagnosis

Even the most classical case of atypical pneumonia must be differentiated from other acute respiratory infections. Patients with pneumonia of bacterial origin such as pneumococcus, streptococcus, staphylococcus, tubercle bacillus, Freidlander's bacillus, and other bacteria are, in general, more severely ill, show frank signs of consolidation, have a high white count, higher fever, different roentgen findings, and the etiologic agent is readily isolated. Diseases caused by known viruses such as influenza, psittacosis, ornithosis, as well as rickettsial diseases and coccidioidomycosis, clinically resemble primary atypical pneumonia. These, of course, can be distinguished from it by isolating and identifying the etiologic agent in the laboratory. One must also differentiate atypical pneumonia from tonsillitis, tracheobronchitis, bronchiolitis, pharyngitis, the common cold, infectious mononucleosis, bronchiectasis, pleural effusion, atelectas, and carcinoma both primary and secondary.

Treatment

To date, there is no proven therapeutic agent which helps or definitely cures all cases of pri-

mary atypical pneumonia. In general, sulfonamide therapy does not affect the course of this disease. Many patients are made more ill by sulfonamides, and some develop toxic manifestations, as we observed in our survey. Both the clinical and roentgen diagnosis of atypical pneumonia is open to error. When the patient is ill with a suspected pneumonitis, sulfonamide therapy is indicated until pneumococcic pneumonia and other bacterial infections can be definitely excluded. When the diagnosis of primary atypical pneumonia is established, sulfonamide therapy should be discontinued.[16]

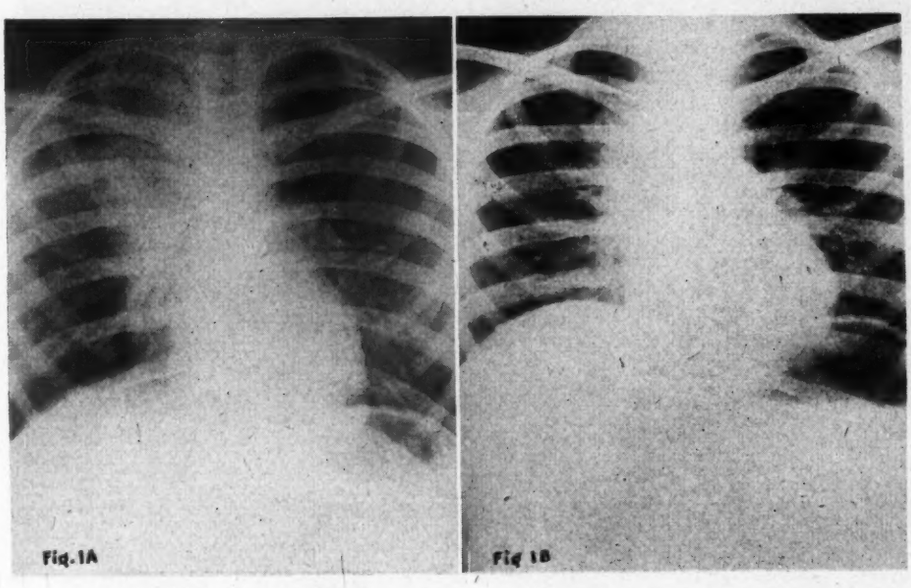

Fig. 1-A. Case 1:B.S. Roentgenogram taken January 26, 1942, showing marked increase in hilar shadows, more marked on the right. There is a diffuse irregular density spreading up from the right hilus.

Fig. 1-B. Case 1:B.S. Five days later on January 31, 1942, there was evidence of clearing of the density in the right upper lobe. The increased hilar markings are still present.

Convalescent serum has not been of any help. We used it in one case four times and this patient is the one who was subsequently autopsied. Young[35] has also used blood or plasma of convalescent patients in eight cases without any specific effects.

In one case, 400,000 units of penicillin were used over a three-day period with no beneficial results. Four other cases in the current literature have reported similar results with the use of penicillin.[7,20]

We have not used roentgen therapy in treating this type of pneumonia. Uhlman[31] has reported 50 cases of atypical pneumonia treated with radiation and noted rapid improvement in some cases. Offett[23] has reported ten cases with similar results. Correll and Cowan[6] reported twenty-three cases treated with x-ray with the distinct clinical impression that roentgen therapy reduced the total sick days, the total days of fever, and the days required to resolve the pneumonic process. We believe these results are promising but not conclusive. In our next series of cases we plan to give roentgen therapy a thorough trial.

At present, the only course to follow is one of symptomatic treatment; bed rest; fluids; diet as tolerated; antipyretics; sedatives; codeine for cough; expectorants if the cough is quite nonproductive; in some instances postural drainage is of value; steam inhalations; throat irrigations, and counterirritants to the chest. Cardiovascular stimulants are rarely indicated, unless there is associated heart disease. Oxygen should be used when indicated for cyanosis or respiratory distress. In occasional cases, the respiratory distress may be so great that helium and oxygen mixture should be used and even under pressure as reported by Barach[4] in four cases complicated with asthma.

Prognosis

Most patients with primary atypical pneumonia recover and the mortality rate is extremely low. Yet one must beware lest this disease in pandemic

form appear with new and so far unheard of virulence. This would be a catastrophe, since no beneficial therapeutic agent is available.

It is not impossible also for the development of virucidal chemical substances as sulfonamides which were bactericidal.

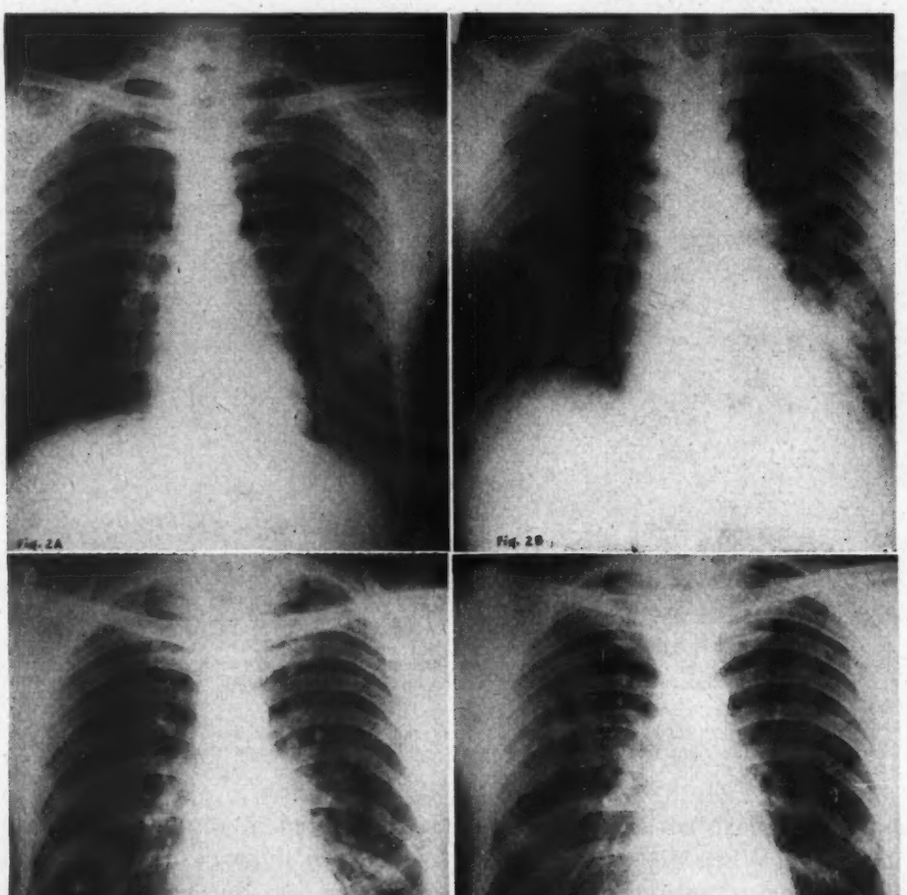

Fig. 2-A. Case 2:R.C. Roentgenogram taken January 14, 1943, shows a definite diffuse patchy density extending down and out from the left hilus.

Fig. 2-B. Case 2:R.C. Four days later on January 18, 1943, there was an increase in the amount and extent of thickening in the lower left lung field with coalescence of the densities to a considerable degree.

Fig. 2-C. Case 2: R.C. On January 28, 1943, there was definite improvement. The density shows clearing. Some thickening is seen in the right costophrenic angle.

Fig. 2-D. Case 2: R.C. On February 15, 1943, thirty-five days after onset of the illness, there was no evidence of pneumonic process; only coarse appearance of lung markings in the left lower lung field.

Let us hope that the progress in its therapy will be spectacular as was the story of pneumococcic pneumonia. The work of Francis and others on the production of immunity to the virus of influenza is a great step. From this may develop anti-virus for immunization and therapy.

Case Reports

The following are three case reports demonstrating the three types of atypical pneumonia previously described:

Case 1.—B. S., No. 1161, a nine-year-old girl, became ill on January 21, 1942, with headache, sore

throat, fever, chilly sensations, and a dry nonproductive cough. Her physician found diffuse rales on examination and felt she had a bronchitis. The temperature ranged between 99° F. and 103° F. She received symptomatic treatment and seemed to improve. Five days later, on January 26, she developed more severe paroxysms of coughing and expectorated a small amount of blood. On the same day, January 26, she was sent to St. Vincent's Hospital. On physical examination, there was decreased resonance in the right upper chest anteriorly with many crackling rales. There were a few moist rales throughout both lungs. The white blood count was 8,200 with 48 per cent polymorphonuclear cells. Several other counts ranged between 7,400 and 11,800 with normal differential counts. Sputum examinations for pneumococci and acid-fast bacilli were negative.

Admission roentgenograms on January 26 showed diffuse irregular density spreading upward from the right hilus region. There was also a marked increase in hilar markings particularly on the right (Fig. 1-A).

This patient was placed on therapeutic doses of sulfonamides. There was gradual improvement but on the fourth hospital day the temperature rose again to 102.3° F. The physical signs remained unchanged. The next day, January 30, she developed a severe maculopapular drug rash. Sulfadiazene was stopped and the remainder of her stay was uneventful. Roentgen examination on January 31 (Fig. 1-B) showed evidence of clearing of the density in the right upper lobe. The increased hilar markings were still present. Physical signs improved, and she was discharged from the hospital on the twelfth day.

This is an example of the mild type of primary atypical pneumonia. This is one of the earlier cases in our series in which sulfonamides were tried without beneficial results.

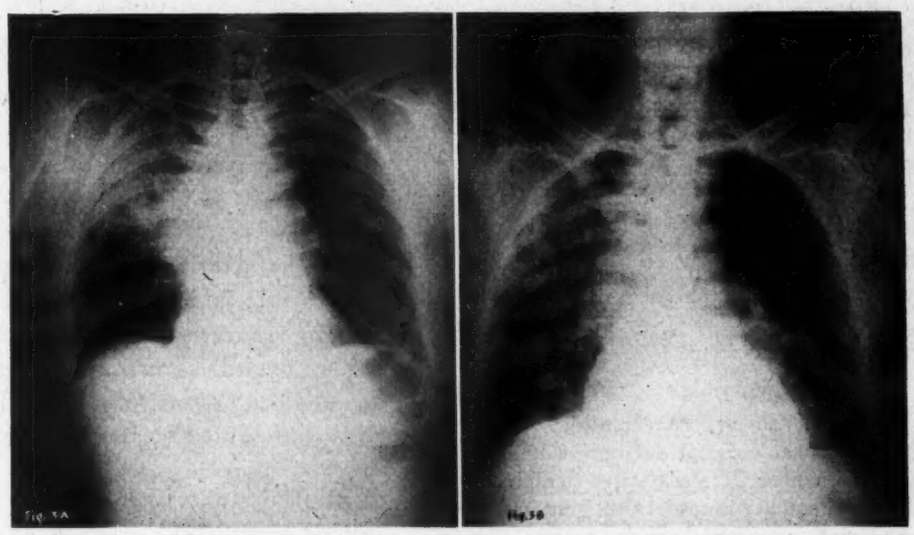

Fig. 3-A. Case 3: M.P. Roentgenogram taken December 29, 1943, shows marked increase in both hilar shadows especially on the right from which extends upward and out a marked irregular increase in density which has a patchy appearance. There is a small patchy density in the mid-lung field on the left.

Fig. 3-B. Case 3: M.P. On January 3, 1944, the amount of involvement in both lungs had increased, including almost the entire right lung and the lower one-half of the left. The irregular patchy character is more prominent. The change on the left side resembles that seen earlier in the upper right lung.

Case 2.—R. C., No. 871, forty-one-year-old white man, developed a severe nonproductive cough, fever, and chilly sensations four days prior to hospital admission. Sulfathiazole had been given by a local physician. On admission, January 14, 1943, the patient appeared moderately ill. The temperature was 103° F. Occasional dry crackling rales were heard posteriorly over the left lower lobe. On admission, sputum examination and typing for pneumococci were negative. The white blood count was 11,200 with 65 per cent polymorphonuclear cells. The urine showed albumen, granular casts, white blood cells, and sulfathiazole crystals. The admission chest film, January 14, showed a definite diffuse patchy density extending downward and outward from the left hilus (Fig. 2-A). In view of the history, physical and laboratory findings, and roentgen examination, the diagnosis of atypical pneumonia was made. Sulfathiazole which was given prior to admission was discontinued when the patient came on our service. General supportive treatment was carried out.

Four days after admission, January 18, the condition of the patient was unchanged. The white count was 13,800 with 71 per cent polymorphonuclear cells. Roentgen examination at this time showed a definite increase in the amount and extent of thickening in the lower left lung field with coalescence of the densities to a considerable degree. The remainder of the lung

appeared relatively clear (Fig. 2-B). Eight days after admission, the condition of the patient improved. The temperature gradually fell to 99° F. Films on January 28 also showed definite improvement, the density showed clearing, and accentuated lung markings were seen through the fading density. There was some thickening in the right costophrenic angle (Fig. 2-C).

Roentgen examination on February 15, thirty-five days after the onset of the illness, showed no evidence of the pneumonic process and only a slightly coarse appearance of the lung markings in the left lower lung field were seen (Fig. 2-D).

This is an example of the severe type of atypical pneumonia which gave little clinical evidence of its severity but showed continued evidence of its extent, roentgenographically.

Case 3.—M. P., No. 16160-279-44, a sixty-year-old white woman, developed an upper respiratory infection on December 15, 1943. Several days prior to hospital admission, on December 29, she became acutely ill with a high fever, generalized muscle and joint pains, profuse sweating, and a severe cough, which was slightly productive of a scant amount of mucoid sputum. On admission to St. Vincent's Hospital on December 29, she was acutely ill. There was marked injection of the pharynx. Coarse scattered rales were heard both anteriorly and posteriorly over both sides of the chest. No dullness to percussion was noted, but the breath sounds were increased and bronchial breathing was noted. Sputum examinations for acid-fast bacilli, pneumococci, and other organisms were negative. The urine showed no abnormality. Admission chest films on December 29 showed a marked thickening of both hilar shadows, especially on the right. The upper portion of the right lung showed a marked increase in density which was irregular and had a patchy appearance. There was a patchy thickening in the mid-lung field on the left (Fig. 3-A).

Roentgen examination five days later on January 3, 1944, showed the amount of involvement in both lungs had increased, and now included almost the entire right lung and the lower one-half of the left lung. On the right side the irregular patchy character was much more prominent than previously. The change on the left side resembled that seen earlier in the upper right lung (Fig. 3-B).

This patient was extremely ill and ran a stormy hospital course. The temperature remained between 103° F. and 105° F. for five days, remained at 102° F. for seven days, and became normal on the twelfth day. She was very cyanotic and required an oxygen tent for nine days. Transfusions with whole blood were used twice. Sulfadiazene was discontinued on the seventh hospital day after no apparent response was noted. She was discharged on the 21st hospital day with a normal temperature.

This is an example of a severe migratory type of atypical pneumonia in an elderly individual who was extremely ill, and failed to respond to sulfonamide therapy.

Summary

1. Primary atypical pneumonia is a definite disease entity. It is a very common disease and is becoming a serious problem in civilian life as well as in the armed forces. The full extent of its prevalence is not realized.

2. It is characterized by an influenza-like onset, headache, fever, severe paroxysmal cough, relatively normal blood picture, few early physical signs, and failure to respond to modern chemotherapy. The diagnosis must be verified by roentgen examination.

3. A clinical study based on 152 cases was reported with three case reports to demonstrate degrees of severity, the clinical course and roentgen interpretations.

4. A discussion of roentgen interpretations of primary atypical pneumonia was given.

5. The pathologic changes are a diffuse injection and inflammation of all the respiratory passages from the pharynx to the smallest bronchi, a patchy consolidation with areas of emphysema between areas of consolidation, and an atelectasis secondary to a bronchiolitis and peribronchiolitis.

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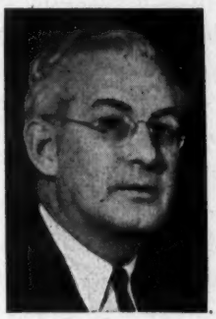
Medical service is a personal service, a matter of personal relation that it is impossible to supervise. Life or death or other serious consequences may rest upon the recognition of responsibility, tireless, careful observation, and the well-informed judgment of the physician. That is not a proper role for those who are emotionally unstable, the irresponsible, or those deficient in knowledge or judgment. The quality of medical service depends upon the quality of the profession giving that service. The present policy of discontinuing medical training except to those rejected from the armed forces and women is a serious error, and contrary to the advice of the best medical men.—R. L. SENSENICH, M.D., before Pepper Subcommittee on Health and Wartime Education.

What a Modern Army Health Service Should Be

By Brigadier Jonathan C. Meakins, M.D.
Montreal, Canada



Professor of Medicine, McGill University Faculty of Medicine, Montreal, Quebec, Canada.

The orthodox concept that an Army Medical Corps is primarily concerned with the prevention of communicable diseases and the curing and healing of specific lesions and injuries is far too restricted. Unfortunately the greater part of the officer personnel are imbued with this idea as it is fostered by the traditional principles of medical education and the requirements of licensing bodies. It is not fully appreciated nor practised that the Army comprises a selected group each member of which is presumably above a certain minimum standard of physiological and psychological fitness. It is the duty of the Medical Corps to provide a Health Service in its broadest meaning and therefore must deal with soldiers from the anatomical, physiological, psychological and social points of view, always bearing in mind that he is being trained to fulfill a role entirely foreign to that of civil life.

■ THE invitation to address you on this occasion was received when I was on active military service with the Canadian Army. Although my leave of absence from McGill University was limited, its duration was not at that time definitely set. It was but natural, therefore, that my inclination was towards a phase of medicine in which I was most actively interested. Furthermore it must be appreciated that my concept of military health service is almost identical with what a civilian health service should be. We need not befog the issue by arguing what is the difference between such a service and health insurance and state medicine.

The present-day practice of medicine is bedevilled by two great deficits; namely, first, an improper distribution of medical practitioners and second, inadequate tools with which to practice our profession, particularly by those in slums, villages and rural areas.

A present-day medical student is trained to

Read before the Fourth Annual Conference on War Medicine, the Seventy-ninth Annual Session of the Michigan State Medical Society, at Grand Rapids, Michigan, September 29, 1944.

the level where all the most up-to-date methods of a modern teaching hospital are employed. When he leaves, after spending a longer or shorter period as an intern or resident, he naturally is dependent to a great extent upon these tools. He is, however, given the alternatives of practising in a large centre where these may or may not be available to him, or in a rural or semi-rural area where they are difficult of access and hence he reverts to practice his profession as in the horse-and-buggy days. The consequence is, on the one hand, an expensive medical service and, on the other, an inefficient although an honest and earnest one.

A further point in this background must be appreciated; namely, that the principal outlook of the medical practitioner is towards gross anatomical diseases and their therapeusis. This explains in large measure why surgical wards are full to overflowing and why so many patients, particularly women, suffer eventually from partial evisceration. The degree of responsibility which should be laid at the door of the state and provincial licensing examination bodies for this outlook is considerable.

In contrast to this organic disease concept it must be appreciated that over 50 per cent of the complaints for which patients seek medical advice cannot be attributed to demonstrable organic cause in the first instance, but are of the mind or the spirit. Furthermore, and additional but not inconsiderable number suffer from so-called minor complaints such as headaches, backaches, footaches, dysmennorrhoea, in which most medical practitioners have but little real interest and hence the populous waiting rooms and flourishing practices of the so-called irregulars.

A military or health service must be all-inclusive of all anatomical, physiological and psychological disabilities. It is true that it has to deal with a selected population not only as to age but also because the majority of those suffering from demonstrable organic diseases have been screened out by the induction and enlistment examinations. But, in spite of this screening, it is surprising how many mistakes are made, such as overlooking the importance of the history in chronic nontuberculous pulmonary diseases and that large group of so-called "rheumatic" conditions, and the overemphasis upon a systolic murmur without any supporting evidence, and also the undue apprehension attributed to a slightly elevated systolic blood pressure without corresponding change in the diastolic pressure. It is in these duties that the medical officer finds himself in a quandary, as he is called upon to make serious decisions without sufficient experience in this group of potentially healthy personnel to be on firm ground. The group of medical officers who are called upon to carry out these duties have probably one of the hardest and also most important jobs in the whole corps. A recruit wrongly rejected is a vital loss of manpower, while one accepted who should not be, eventually represents a great loss in money and precious training time of skilled personnel. Therefore, these officers should be specially selected and trained for this most important but withal monotonous task as it is so different from their traditional role. The same applies to analogous practice in industry.

There was a time when it was considered to be the medical officer's duty practically to assign the recruit to a certain corps or service. This might have been satisfactory, although I doubt it, when the art of war was relatively simple as compared to the multitudinous jobs which the present-day soldier has to do. His physical, mental and emotional qualities must all be taken into consideration. This requires a particular discipline and is *in toto* beyond the capacity of the medical officer. It is his duty to describe honestly the soldier's physical condition in degrees of capacity based on a combatant soldier's requirements; in other words, his functional attributes relative to the perfect man. His adaptability, craftmanship, intelligence quota, literacy, are assessed by others and while his emotional background is judged by the psychiatrist he is allocated to the job he can probably do best. This process is a combined effort by all concerned; but, in the last analysis it is the Army Examiner who is the judge of the soldier's destiny. This whole undertaking cannot be a perfunctory process placed in the hands of unskilled and haphazard personnel. It is one of the most crucial assessments in the whole fabric of the Army as the results determine the quality of the fighting arm as well as the smooth and intelligent functioning of supply, armour, communications, and the hundreds of special jobs which must be done with as near perfection as possible in a successful Army the personnel of which is divis-

ible into the killers and the tradesmen. The former are many times indistinguishable from the latter, but the whole mosaic must be perfect and complete.

To separate or divorce what we call "Personnel Selection" from a composite organization which includes the Medical Corps is the epitome of stupidity. Through the whole of a soldier's career his physical or emotional conditions are subject to fluctuations of excellence; so is his usefulness to pull his weight to ultimate success. He is being trained or is trained to be a soldier and the longer this process lasts the more useful he will be in some arm of the Service, as many of the skills are interchangeable.

The next chronological step in the duties of the Medical Corps, although inverse or, perhaps, intermediate in regard to age of experience, is that of the regimental medical officer. He is really the key man and his counterpart in civilian life is the general practitioner and all that this should imply. We should visualize what these duties are. He has under his immediate responsibility the health and happiness in a new society of approximately one thousand fighting men. His charges, until they become veterans and have completely dissociated themselves from civilian life, are in the process of continual training. They are, therefore, needful of both physical and psychological surveillance. The physical efforts are more than most have been accustomed to and of a different variety. Muscles that were silent from disuse suddenly become articulate in protest to unusual effort. The recruit is apprehensive of an unknown world and these aches and pains afford a focus upon which he concentrates to provide him with a tangible explanation for his apprehension. It must be appreciated by the medical officer that his charges are a picked group of men and women in the heyday of life, and that all obvious anatomical and even suspicious emotional diversions have been already eliminated.

But the proper duties of the regimental medical officer does not stop here. A citizen army, whether volunteer or drafted, is in its very essence a social eruption for its members. They have left a life of seeming independence with friends and family within an accustomed environment, to be translated into an entirely different society. It is a more civilized one although directed to killing and being killed. The recruit does not appreciate as yet the wonder of this comradeship of arms. He is fearful and anxious not only as to his own destiny but also for his family and dependents. It is here that the commanding and medical officers may be at a loss as to how to cope with these situations which, although individualist, in their multitude become a veritable mass. These officers are not trained, nor have they time or facilities, to handle this multitude of diverse problems. It has been traditional to consider that the Padre is the man to solve all matters of emotion which are supposed to stem from the so-called soul as represented by faith. But faith in what? These problems are not of religion but usually in a biological and economic sense, of the earth—earthly. They stem from the mundane but personal things of a man's life. It is in regard to these aspects that the Medical Corps must be broad and as comprehensive as in civil life, in fact, more so.

The so-called social sciences have a great role to play and their disciplines must be used by the realistic Medical Corps not as subservient to medicine but as a partner, both working to the same end, namely, the complete physical and emotional equilibrium of the perfect soldier. The multitude of problems which the trainee and fighting soldier have to bother them are not of the body alone, but are in great measure from beginning to end of the emotions also. The trainee taken as a mass wants to know a thousand and one things which no medical officer could know the technique or have the facilities to explain. The social worker can. I would here emphasize the fact that these officers must be professionally competent and not amateurs, and may be of either sex. In fact, a female social welfare officer may, under certain circumstances, be better able to solve problems which are of the most difficult character and with their solutions soldiers are made. It must be reiterated that this social work cannot be carried out by well-wishing amateurs. This work requires well-trained professional personnel. It is different in some ways from traditional civilian requirements as is that of the medical officer.

It is interesting and withal at times amusing to look back on the development or progress of our concepts of many of the causes of casualties from the Army. A casualty may be defined as a soldier—officer or other rank—who has ceased to be useful in the role to which he has been trained

and cannot be usefully employed in any other capacity. But the published casualty lists usually enumerate those who have had traumatic injuries or die from severe infections such as malaria, typhus, infectious jaundice, scrub typhus, dysentery, venereal disease, et cetera, although most of these have accounted for many times more manpower days lost than have battle injuries. In addition, there is that group of disabilities which are seldom referred to in official lists, namely, the psychosomatic syndromes, the frankly psychiatric casualties, and those variously grouped under battle-fatigue, exhaustion, and other synonyms, which would imply that they occur only in front-line soldiers. Nothing could be farther from the truth. It is true that these conditions do occur in front-line soldiers and to a great degree are amenable to prompt treatment by competent psychiatrists or medical officers who, although not so trained as specialists, have an understanding of the problems involved and their solution.

Any active army in the field depends upon reinforcements of manpower as well as armour and munitions. This manpower supply can only come from the manhood of the country. It is well known that approximately 50 per cent of the rejections of recruits is on account of emotional or psychiatric reasons and that during training and in preparation for battle a large percentage of those who fall by the wayside and have to be reduced in grade or even discharged from the army suffer from the same disabilities. The primary origin of these casualties is to be found in family and social reasons. The old adage that "everyone is crazy but thee and me, and thou a little bit" has been well demonstrated in the past five years. The incidence of these conditions is much lower in the voluntary recruits than in draftees. It would, therefore, seem obvious that motivation to fight for one's country with a single-mindedness of purpose is prompted by an emancipation from those personal and social ties or emotional restrictions which loom so large in the oedipus domination. Many of these individual problems are amenable of solution but not immediately by the medical officer. If he has the concept he does not have the time or the facilities to pursue the investigation to its ultimate conclusion. Unfortunately in many instances he does not appreciate the full import of the situation and deals with the soldier in a manner which is antagonistic, or to say the least, unsympathetic and devoid of understanding. Unfortunately many of the traditions as to the proper behaviour on the part of combatant and medical officers towards the recruit stems from the hard-boiled attitude in vogue in the mercenary or regular army. This does not go in a citizen army where every man is potentially as good as his fellow in civil life but may have trials, troubles and phobias which loom large in his cosmos in this transition from a peaceful, law-abiding person to a "killer."

Therefore for a large per cent of the casualties in training and in battle, the medical officer does not have the proper therapeutic armamentarium. His pills, potions and surgical procedures may do more harm than good as they will confirm the emotional or harassed patient in his belief or give him reason to be convinced that his vague pattern of symptoms are indicative of an organic disease the apprehension of which still further aggravates his disability. All such cases can be best handled by a judicious and sympathetic hearing by the medical officer and a proper concept that all complaints do not necessarily have an organic foundation. At this point he should have available his professional social worker who would carry on the history and by a well co-ordinated organization delve into the social and family background. Illness at home, an impending baby, economic stress, a bad crop, long silence from wife or sweetheart, and dozens of other causes may mean the difference between unrest and worry and the happy warrior. This provision of social medicine must not be perfunctory or casual and carried out by the amateur. It must be well organized and have its contacts and ramifications over the lands bordering the seven seas. A soldier in Africa, Italy, France, England, or the South Sea Islands may be the victim and officially, through his officers to whom he looks with faith and confidence, contact with his home or other source of discomfiture must be possible. This is equally applicable to the boy from Iowa in Florida, from Maine in California or from Quebec in British Columbia. This means a well-knit organization not separate from, but intimately associated with, the medical officer, in fact an integral part of the Medical Corps. I know there is a fear on the part of some that the social workers will become subservient to the medical officer and

not have a free hand in their professional sphere. If such were the case, the medical officers would be chauvinistic and intolerable pedants and should be properly disciplined by superior authority. On the other hand, the social workers must appreciate that they are part of a team and are not commissioned as independent therapeutic agents. It must be appreciated by the social workers that they have ofttimes in civil life made themselves suspect by their unprofessional arrogance and have antagonized their medical colleagues by untactful criticism as often as medical reaction and indifference have seemingly ignored their proper place in the common goal to enhance human health and happiness.

In the third phase of the Medical Corps we find its officers more at home in their traditional role—namely, the diagnosis and therapy of organic disease. It is interesting but understandable that this is the type of work to which they all aspire. For the Army's point of view, if we are realists, it is of lesser importance than the first or second, whereas to the humanist it takes precedence. The usual visceral diseases, if they have a disabling aftermath, require expert diagnosis and therapy before discharge, but these cases are relatively few as the army population is a well-selected one and falls in the age groups when such diseases are few unless they follow rheumatic fever or tuberculosis contracted in service. As already pointed out, the majority of medical conditions fall into the infectious disease group. For these the primary responsibility of the Medical Corps is prevention. It is the duty of every medical officer to contribute to this end and there is no excuse for failure whether it be due to venereal disease, tetanus, scarlet fever, mumps, smallpox, diphtheria, malaria, dysentery, typhoid fever, infectious jaundice, typhus, scrub typhus, plague, yellow fever, or what have you. The occurrence or continuance of any of these must be viewed as an acknowledgment of failure. I appreciate that Utopia cannot always be attained, but a fatalistic attitude or one that shifts responsibility to someone else's shoulders cannot be accepted by higher authority. It is true that the medical officer has but limited command, but he has authority none the less. He is adviser to the commanding officer whether of company, regiment, brigade, division, corps or army. If his advice is not followed, he can and must appeal to higher authority. Many manpower days are lost from preventable diseases, and the essence of the reduction of these is through rigid discipline of indicated techniques. It is one of the first duties of the medical officer to see to it that all protective inoculations are meticulously carried out. To my mind any breach of this duty should be the subject of disciplinary action of which there is far too little in the medical services. An error of judgment is but human, a neglect of an order is a crime.

This is the first war where a psychiatric branch of the Medical Corps has really come into its own. For security reasons the magnitude of its responsibility will not be stated, but it is most important to appreciate that in a well-organized service its salvage value to the fighting forces is almost equal to that accruing from the prevention of infectious diseases. A trained soldier or veteran returned to the firing line is equivalent to one and a half recruits. These cases all come under the notice of the regimental medical officer in the first instance and unless he is knowledgeable of what can be done and how to do it, he is delinquent of his duty. The same may be held in civilian practice.

Contrary to conditions in civilian life, the surgeon has a numerically minor role in handling of disabilities. It is true that those due to enemy action are more often a menace to life and limb. Further they are more harassing to the emotions of relatives and the soldier is apt to be exposed to more suffering. There is also an appeal to the spectacular in the action of sulpha drugs, penicillin and blood substitutes, but these are all of little avail unless proper surgical procedures are carried out. This requires sanity and a knowledge gleaned from the past experience of wars which is too often neglected. But in this aspect I am probably getting beyond my competent role. I would crave, however, to pay a sincere tribute to our young surgical colleagues who have pressed forward to a short distance behind the firing line to bring their skill to the wounded soldier. Their exposure to the dangers of the fighting man has probably done as much, through treating wounds early, to reduce the eventual morbidity and mortality as have the other agents already mentioned. But these triumphs of medical service are restricted to the privilege of the relatively few and are in large measure made possible by the devotion and courage of the general practitioner of the Medical Corps, namely,

the regimental officer. It is an unfortunate commentary on the Medical Profession that so many crave to serve in a military hospital where the work is humdrum and easy as compared to their colleagues in the regiment, field ambulances and field surgical units. This indicates a rather arrogant attitude which should not be encouraged, particularly amongst the young, and has an important lesson for those who aspire to direct the changing order in civilian practice. I have already stated that there is a disproportion in the distribution of professional facilities. It may be taken today as an axiom that the consultant is one with all the modern technology of medical practice at his immediate command. Without these he would be lost. So it is in the army, and according to his training the young medical officer wishes to serve in a hospital, as he has at home, where most things are done for him by technicians, officers, sergeants, corporals and privates. He is provided with a service which few have had before and which he will crave when he returns to civil life and without which he will not be happy.

The fourth stage of the medical service is one that is not properly appreciated by our administrators and so-called statesmen, namely, the preparing of the soldier for return to civil life. Ten per cent or thereabouts of our men and women have been transformed into a new society and have lived in it for a longer or shorter period. All have psychologically changed and many also have changed physically. In their reorientation to civilian life the medical profession must play an important part. It is not enough to hold or consider that we are only interested in their diseases and mutilations. Their whole health, physical, psychological and social, is our grave concern. Furthermore, this concept must be put into action as soon as a soldier is injured to such a degree that he is probably no longer likely to be an efficient soldier, or when the order to cease firing is given. It would seem obvious that this can best be done by those who helped train him to be a fighter or commanded him during battle and looked after his illnesses or injuries and know his psychological makeup as compared with well-intentioned civilians, even veterans of the last war. I cannot overemphasize the role which the Medical Corps should play along with their fellow officers in other corps. I know you have regulations to this end, but see to it that the medical profession does not falter or fail in this great opportunity to prove their worth and fulfill the trust which they abrogate to themselves by virtue of their Hippocratic charter.

Woven through what I have said there is implied an analogy or counterpart to what civilian practice should be. There are fundamental principles in a well-organized army health service which are equally applicable to civilian practice. We civilians restrict ourselves too rigidly to the diseases to which we can give a specific organic basis and forget the emotions and environment of the man whom it may or may not inhabit. The medical profession has to my mind failed in its trust because it has not demanded proper tools for the less privileged of their colleagues. Further, it has not viewed its domain as "health" as distinct from "disease." As pointed out for the army, less than fifty per cent of all disabilities including battle casualties are attributed to demonstrable anatomical lesions or diseases, so it is in civilian life and we pay little interest to these other unfortunates.

The Army Medical Corps is concerned with clothing, nutrition, housing, recreation, family relations, economic conditions and a multitude of ancillary factors as well as disease which interferes with the well-being and production of the fighting man. Why should this be not so in civilian practice? The answer is that we as individuals are not paid for these details, but only to correct the effects of their abuses. This would never be tolerated in the army. The battle would be lost as it almost was before it had begun. So it is in civilian life. We do not have to fuss and fume about state medicine or health insurance. Let us pattern our programme on the concept of a military health service. We as a collection of individual medical practitioners can so conceive a medical Utopia or democratic medical Society where there is security for all, arrogance for none and comradeship and loyalty to those who have proven their worth to guide us to a promised land. These moses's must, however, be of our own choosing and not of a Pharaoh who is influenced by political exigencies; in other words, patronage and a resulting majority of favorable votes.

Andrew P. Biddle Endows Postgraduate Medicine

The late Andrew P. Biddle, who practiced medicine in Detroit for over fifty years and who died August 2, 1944, at the age of eighty-two years, generously endowed the Michigan State Medical Society Foundation for Postgraduate Medical Education and the Department of Postgraduate Medicine of the University of Michigan. Together with his wife, the late Grace W. Biddle, our Past President willed the bulk of his estate of over $80,000 for the continuation of postgraduate medical work.

The House of Delegates of the Michigan State Medical Society, at its Grand Rapids Session of September, 1944, adopted a resolution memorializing Dr. and Mrs. A. P. Biddle. The Council authorized the transfer of sums immediately payable and those to come from the residue of the estate to the MSMS Foundation for Postgraduate Medical Education. In all, the Postgraduate Foundation of the State Society will eventually receive approximately $40,000. This great sum, together with the original contribution of $10,000 made to the MSMS Foundation by the Council several years ago, will bring the Foundation total to approximately $50,000.

The Michigan State Medical Society Foundation for Postgraduate Medical Education was created by The Council in May, 1942. Dr. Biddle's great contribution justifies the foresight of The Council. His extreme generosity should serve as a noble example to be followed by other Doctors of Medicine and laymen interested in continuing medical education.

A. S. Brunk

President, Michigan State Medical Society

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President's

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EDITORIAL

WHAT THE PUBLIC THINKS OF US

■ The survey of public opinion of the Michigan medical profession has many lessons to which we must give heed. Probably the most gratifying response shows the high esteem in which the profession is held: 81.3 per cent would advise a son to enter the profession; 91.6 per cent thought that the majority of doctors were doing a good job for the public; 60.8 per cent thought that doctors are as honest as they should be in their dealings with patients; and in choosing between forms or plans of medical service, 60.3 per cent selected that sponsored by the medical profession (33.7 per cent a medically operated prepayment plan, and 26.6 per cent the present private practice plan of paying the doctor for services as rendered). This is good reading, but why not 100 per cent?

They think well of us.

Eighty-one and three-tenths per cent would advise a son to enter the profession. Of the 18.7 per cent who would not so advise, 10.7 per cent do not "care for the profession," 1.7 per cent mention the doctor's bad moral characteristics or ethics (the only group opposing because of bad opinion), and 0.9 per cent are anti-medicine from a religious or other reason. Forty-five and three-tenths per cent think the profession too difficult, 21.5 per cent think the son should make his own decision, 3.0 per cent don't know why they so advise and 5.2 per cent gave no answer. The balance think the profession overcrowded, expect changes after the war, think the responsibility too high, or give other miscellaneous reasons. Better than one out of six of those voting against the profession have a reason demanding our attention, and efforts to improve. They may be wrong and we right, but this is their opinion, and something has prompted it.

They think we are doing a good job.

Ninety-one and six-tenths per cent of the people in Michigan think we are doing a grand job. Four and two-tenths per cent have not made up their minds and 4.2 per cent of the public do not think the doctors are doing a good job. Why? Of this 4.2 per cent 24.2 per cent think doctors overcharge, 21.3 per cent think doctors keep their patients waiting too long. Ten and one-tenth per cent think doctors do not take time to diagnose properly, 5.8 per cent think doctors are dishonest, and a like number think they do not do enough research, are not intelligent enough, and a similar number think that the doctor's first interest is not in curing the patient. Four and three-tenths per cent think the profession is a racket and a like number complained, of all things, that the doctors neglect the people in favor of the Army. Three and four-tenths per cent think doctors prescribe unnecessary or expensive treatments.

Are we honest?

In sampling opinions of 4,968 persons, 1,393 were found who do not believe that doctors are as honest as they should be. This is a reaction scarcely expected, and one that must be closely studied. We as a profession cannot expect to fully succeed with 28.2 per cent of the population not trusting us. Every doctor must examine himself and find and eradicate the offending trait. Here are the reasons given. Forty-one per cent of the 28.2 per cent think doctors do not tell the truth, don't give all the facts, don't give a true diagnosis, or won't admit they do not know what is wrong. Eighteen and two-tenths per cent think the doctors overcharge, rob the public, are too aware of social position, or use the profession for social advancement. Fourteen and five-tenths per cent think that doctors give or order too many and unnecessary expensive treatments. Five and eight-tenths per cent charge the doctors are indifferent or neglectful, don't take enough time for a proper diagnosis, or spend enough time with their patients. Seven and eight-tenths per cent think doctors are dishonest for the patient's own good. The balance come under the complaints that they frighten patients, exaggerate, create fear, or refuse to call specialists or counsel. A few think medicine a racket, and some of course do not know why they think the doctors are dishonest (5.1 per cent).

Government or private control of medicine?

Two thousand one hundred twenty-six persons, or 42.8 per cent of the people queried, do not favor a government-operated medical-hospital plan, and 38.7 per cent think we should have it. This is a margin in our favor, but not so wide that it could not be changed, and changed quickly: 2,126 against 2,064. Of those favoring government control 54.9 per cent think it would provide necessary care for all, and especially the poor; 12.4 per cent think it would cost less. Seven and two-tenths per cent think the government should have control, and a similar number think it would be a more satisfactory plan. Three and five-tenths per cent think it would raise the standard of the medical profession and 3.2 per cent think it would improve public health. It is interesting that 3.2 per cent of those opposed to government control think it would lower the standards of the medical profession.

This brief analysis shows there are too many people that do not like us, and the reasons they give. These can mostly be eradicated by individual and by concerted effort. The future of the practice of medicine depends upon this effort being made. It must be by individual effort—made by EVERY Michigan, or American, Doctor of Medicine!

REPLIES TO CRITICISM

■ THE Public Opinion Survey just finished gives us some criticism that obviously is readily answered. First that the doctors keep patients waiting too long in their offices, or in responding to calls. This comes from 21.3 per cent of the 4.2 per cent who do not think we are doing a good job under these wartime conditions. Of course they may refer to other times and conditions, but now with the shortage of doctors of medicine for the home services, it is surprising how well the people are cared for.

Some men try to see all patients by appointment, and there is then a necessary delay. Frequently appointments are for two and three weeks in advance. Many of us have abandoned the appointment scheme (except for special out-of hours cases), and have the patients wait their turn, explaining kindly and carefully that a third more patients can be seen that way—it is true at a discomfort—but the patients can see that the doctor is working at high tension and doing his best. It is surprising how many patients comment on the stress, and marvel how the doctor keeps up the pace. This definitely spikes the complaint of needlessly keeping people waiting too long.

Each of us must study the other complaints as they relate to us, and the cure must come from within the ranks of the profession.

THE SEVENTY-NINTH ANNUAL SESSION

■ THE Seventy-ninth Annual Session of the Michigan State Medical Society is now history. There were fewer in attendance than was hoped, but those who did attend saw one of the greatest postgraduate medical conferences. Michigan's plan of many out-of-state speakers draws attendance, and brings to us the outlook and thought of medical leaders throughout the nation. This year was up to the high standard of the past, in spite of the difficulty of promising to participate in a program months in advance, when wartimes make all things uncertain. (One of our speakers this year was ordered overseas just the week before our meeting, but sent his paper along, and it was well received.) Great credit is due to our secretariat, and the Scientific committee for a grand job.

ON THE RUN . . .

When there is a leukocytosis accompanying mesenteric thrombosis, there is rarely an increase in the percentage of polymorphonuclears.

• • •

Pentothal can be extremely dangerous to shocked or severely toxic patients unless it is given slowly and in very small doses.

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About twenty per cent of cases of polycystic kidneys show congenital cysts in the liver.

• • •

Sulfabenzamine is a new sulfonamide developed to combat the anaerobic organism causing gas gangrene.

• • •

When patients with angina pectoris fail to show an increase in exercise tolerance after the application of heat or the administration of vasodilators, the prognosis is indeed poor.

• • •

A slight rise in temperature and a persistently elevated pulse rate, without apparent cause, after the fourth of fifth postoperative day, should stimulate a search for other signs of latent thrombosis.

• • •

Intravenous morphine is often sufficient for the cleansing of burns or for painful dressings.

• • •

ACS, anti-reticular cytotoxic serum of Bogomoletz, is reported capable of stimulating the body to resist the degenerative changes of age by stimulating the reactivity of the connective tissue cells.

• • •

In experiments on embryo chicks, streptomycin, from Actinomyces, has been found effective against several gram-positive and negative organisms.

Selected by W. S. REVENO, M.D.

Michigan Health Council

The progress of the Michigan Health Council during its first year has been rather typical of that of new enterprises, in that it has been concerned largely with organization, with the definition of objectives, and with the laying of groundwork for future constructive activities. The objectives already have been reported, and the organizational work has consisted primarily of the incorporation of the Michigan Health Council as a nonprofit agency and the opening of offices, with an executive director, in the Washington Boulevard Building, Detroit.

Most significant for the future, however, are such Health Council projects as a survey of public opinion in Michigan which has just been completed. Before initiating the survey, much consideration was given by the Health Council to the problems which confront the medical profession and the hospitals in their relationships with the public. It was felt that certain unsympathetic public opinion, as well as much of the public support for such measures as the Wagner-Murray-Dingell Bill, could be traced directly to lack of public understanding of the profession and the hospitals.

The Health Council members decided that a joint program of education to correct public misconceptions would be desirable. It was further believed that the profession and hospitals would be interested in ascertaining just what kind of services the public wants, and in considering the steps that might be taken toward a better meeting of public desires. Factual information was lacking; what was known about public attitudes was largely a matter of hearsay or opinion.

To get the facts, a survey was authorized in the spring of 1944, the General Research Bureau of the advertising firm of Foote, Cone & Belding (formerly Lord & Thomas) was hired for this purpose, the field work took place during the summer months, and the report on the survey was completed and reported upon in Grand Rapids at the 79th Annual Session of the Michigan State Medical Society.

In general, the survey shows that the medical and related professions are held in high esteem by the public, that the people are seriously concerned with the economic problems involved in obtaining adequate health care, that there is broad public demand for pre-payment programs to assist in meeting these problems, and that only a small minority of the people favor compulsory governmental programs when voluntary pre-payment, especially under professional sponsorship, is available to them.

The survey contains a wealth of information of value to each of the Health Council's parent organizations. The collective implications of the survey findings will be examined by the Health Council, and it is likely that definite recommendations will be made.

Meanwhile, the Health Council already has taken the initial steps toward public education. Under sponsorship of the Council, Mr. Floyd E. Armstrong, professor emeritus of economics and finance for the Massachusetts Institute of Technology, has delivered approximately 30 public addresses before groups throughout Michigan. In these talks he particularly emphasized the advantages of the private practice of medicine and the merits of the voluntary hospitals. Plans currently are being made for an active itinerary of further talks by Prof. Armstrong, by Prof. Paul D. Bagwell, head of the department of speech and dramatics of Michigan State College, and by other qualified laymen.

Among other educational activities already initiated by the Health Council might be listed the distribution and preparation of literature and other printed material to doctors and hospital administrators, and the establishment of a preliminary library of material on medical and health economics for the use of physicians, hospital administrators, health service plans and other interested organizations.

It will be recalled that the Michigan Health Council originally was called into being because there existed a need for an agency to serve as a clearing house for the four sponsoring organizations and for the presentation by these organizations of a united front on matters of common interest. In serving this purpose, which is largely intangible, the Health Council has begun to demonstrate what is believed to be definite usefulness.

For example, a special committee of the Health

(Continued on Page 1008)

MICHIGAN HEALTH COUNCIL

(Continued from Page 1006)

Council is studying a proposed amendment to the Constitution of the State of Michigan which would create a comprehensive compulsory social insurance system, including health insurance, in this State. This committee has analyzed the proposal thoroughly, and will be in a position to make immediate recommendations should it appear that the amendment proposal actually will be carried to a popular vote.

The Health Council further has considered and indorsed plans for the survey of the hospitals of Michigan which is being sponsored by the Michigan Hospital Association. Another matter under current consideration is a proposed bill for the licensing of hospitals in Michigan, which also is a project of the Michigan Hospital Association. Various other matters have been referred to the Health Council for review and comment by the sponsoring organizations.

On a broader scale, the effectiveness of the Council thus far and its promise for the future have led to a feeling that similar organizations could be of value to the health professions throughout the United States. The Council has made preliminary plans for contacting the medical professions, the hospitals, and the pre-payment plans of other states with a suggestion that consideration be given to the development of local health councils. The establishment of a national co-ordinating agency, perhaps to be known as the American Health Council, would seem to be an ultimate goal.

The sponsors of the Michigan Health Council, as will be remembered, are the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service. The first two organizations are represented on the Health Council by three members each; the two pre-payment plans each have representation by two members.

For the Michigan State Medical Society—A. S. Brunk, Md., C. E. Umphrey, M.D., and Wm. J. Burns.

For the Michigan Hospital Association—Graham L. Davis, L. V. Ragsdale, M.D., and L. S. Woodworth, M.D.

For Michigan Medical Service—R. L. Novy, M.D., Jay C. Ketchum.

For Michigan Hospital Service—William J. Griffin, and W. H. Lichty.

In addition, the Health Council is so constituted that representation may ultimately be given to other groups, and some such other groups—notably, the Michigan State Dental Society—already have expressed their interest in the Council's activities.

The officers of the Michigan Health Council are: President, A. S. Brunk, M.D.; Vice President, Graham L. Davis; Secretary, William J. Burns; and Treasurer, J. C. Ketchum.

Thus far, the Health Council has been supported financially by contributions of $5,000 each from the Michigan State Medical Society and Michigan Medical Service, with an equal amount from the two hospital organizations. Total contributions thus amount to $20,000. Of this amount, some $9,000 is set aside as the expense of the survey of public opinion, and disbursements have amounted to $3,038.63 as of September 12. Slightly more than half of the disbursements have covered fees and travel expenses connected with public addresses sponsored by the Health Council, and the balance has gone into salaries, office rent, and incidental expenses. The unexpended balance on Sept. 12, 1944, amounted to $7,842.91.

What the Michigan Health Council has sought is a constructive program of mutual benefit to the medical profession, the hospitals and the public. The projects undertaken to date should be of definite help toward the realization of that program.

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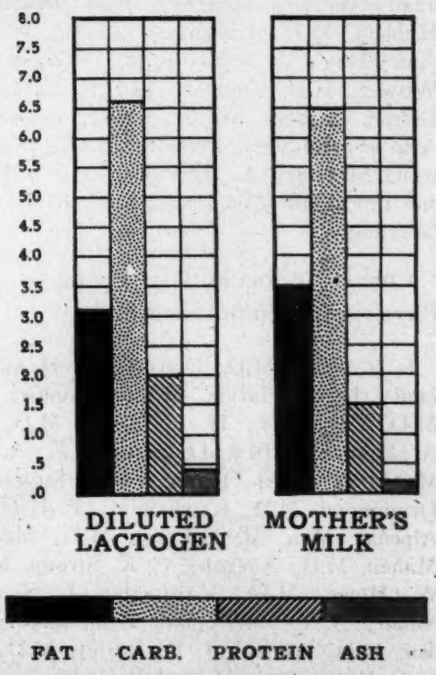
JOHN LOVETT MORSE, *A.M., M.D.*
Clinical Pediatrics, p. 156.



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Michigan Physicians Committee Organized

The Michigan Physicians Committee, a branch of the National Physicians Committee, was organized at a meeting held in the Book-Cadillac Hotel, Detroit, on Wednesday, October 11. Representatives from MSMS Councilor Districts in all parts of the State were present at the meeting to hear Edward H. Stegen of Chicago outline the activities and the program of the National Physicians Committee.

Officers of the new organization were elected. C. E. Umphrey, M.D., Detroit, was chosen as Chairman and Wm. M. LaFevre, M.D., of Muskegon, was selected as Vice Chairman. The Secretary is E. R. Witwer, M.D., Detroit, and the Treasurer is W. D. Barrett, M.D., Detroit.

The organizational meeting was called at the suggestion of The Council of the Michigan State Medical Society. Present at the Detroit meeting were:

E. F. Sladek, M.D., Traverse City, Chairman and O. O. Beck, M.D., Birmingham, Vice-Chairman of the Council; Councilors C. E. Umphrey, M.D., Detroit; R. S. Morrish, M.D., Flint; O. D. Stryker, M.D., Fremont; Wilfried Haughey, M.D., Battle Creek; R. J. Hubbell, M.D., Kalamazoo; Dean W. Myers, M.D., Ann Arbor; A. B. Smith, M.D., Grand Rapids; E. R. Witwer, M.D., Detroit; and P. L. Ledwidge, M.D., Detroit, Speaker of the MSMS House of Delegates. Also present were President A. S. Brunk, M.D., Detroit, Secretary L. Fernald Foster, M.D., Bay City, and immediate Past-President C. R. Keyport, M.D., of Grayling.

Others at the initial meeting of the Michigan Physicians Committee were:

L. W. Hull, M.D., Detroit; H. H. Gay, M.D., Midland; L. C. Harvie, M.D., Saginaw; R. L. Wade, M.D., Coldwater; H. R. Moore, M.D., Newaygo; C. A. Paukstis, M.D., Ludington; E. A. Oakes, M.D., Manistee; E. J. Bolan, M.D., Suttons Bay; Fred Drummond, M.D., Kawkawlin; F. J. O'Donnell, M.D., Alpena; Wm. M. LeFevre, M.D., Muskegon; J. E. Mahan, M.D., Allegan; C. K. Stroup, M.D., Flint; L. W. Howe, M.D., Marquette; J. S. DeTar, M.D., Milan; D. T. MacDonald, M.D., Monroe; E. T. Morden, M.D., Adrian; J. H. Burley, M.D., Port Huron; L. S. Woodworth, M.D., Detroit; A. V. Wenger, M.D., Grand Rapids; C. A. E. Lund, M.D., Middleville; H. G. Huntington, M.D., Howell; T. Y. Ho, M.D., St. Johns; K. T. McGunegle, M.D., Sandusky; Wm. J. Burns, Executive Secretary, Michigan State Medical Society; and J. A. Bechtel, Executive Secretary, Wayne County Medical Society.

Sponsoring Committee

All Doctors of Medicine present at the Detroit meeting of October 11 will form a Sponsoring Committee for the Michigan Physicians Committee. In addition, the following representative physicians in various parts of Michigan, designated by MSMS Councilors, have also been invited to become members of the Sponsoring Committee:

V. M. Moore, M.D., Grand Rapids; Wm. A. Hyland, M.D., Grand Rapids; J. Milton Robb, M.D., Detroit; G. L. McClellan, M.D., Detroit; B. I. Johnstone, M.D., Detroit; Arch Walls, M.D., Detroit; R. C. Connelly, M.D., Detroit; S. W. Insley, M.D., Detroit; T. K. Gruber, M.D., Eloise; R. L. Mustard, M.D., Battle Creek; R. A. Springer, M.D., Centerville; L. E. Holly, M.D., Muskegon; T. P. Treynor, M.D., Big Rapids; G. B. Saltonstall, M.D., Charlevoix; C. S. Clarke, M.D., Jackson, Luthur W. Day, M.D., Jonesville; Paul Engle, M.D., Olivet; W. E. Barstow, M.D., St. Louis; G. H. Frace, M.D., St. Johns; A. L. Arnold, Jr., M.D., Owosso; H. M. Best, M.D., Lapeer; E. W. Blanchard, M.D., Deckerville; E. C. Sites, M.D., Port Huron; N. L. Lindquist, M.D., Manistique; W. H. Huron, M.D., Iron Mountain; C. T. Menzies, M.D., Iron Mountain; H. L. Sigler, M.D., Howell; J. E. Church, M.D., Pontiac; M. M. Wilde, M.D., Warren; W. D. Barrett, M.D., Detroit; T. I. Bauer, M.D., Lansing.

"The work of the Michigan Physicians Committee," stated Chairman Umphrey, "will begin at once and will be patterned after the modern outline of activity developed by the National Physicians Committee and explained at the Detroit meeting by Mr. Stegen. The Michigan Physicians Committee will work in the interest of better Medicine, the preservation of all that is valuable in the present American type of private practice, together with the encouragement of supplemental features, where needed, to the end that good medical care is distributed to all in this State who need it. The Michigan Physicians Committee is dedicated to a progressive program of modern medical service to all."

COUNTY SECRETARIES CONFERENCE IN GRAND RAPIDS

Eighty persons attended the County Secretaries Conference held September 27, 1944, on the occasion of the 79th Annual Session of the Michigan State Medical Society in Grand Rapids.

The interesting program included an outline of "Health Insurance Proposals in Canada" by F. A. Brockenshire, M.D., Windsor, Canada, immediate Past President of the Ontario Medical Association; "Nebraska's New Medical Practice Act," was explained by M. C. Smith, Lincoln, Nebr., Executive Secretary of the Nebraska State Medical Association; and "The Michigan Picture in Medicine," an outline of current events of interest to county society officials and members, was presented by L. Fernald Foster, M.D., Bay City, MSMS Secretary.

T. Y. Ho, M.D., St. Johns, Chairman of Secretaries, acted as toastmaster.

The thirty-one county society secretaries present at the Conference were:

E. B. Andersen, M.D., Dickinson-Iron; Helen S. Barnard, M.D., Muskegon; Paul H. Bassow, M.D., Washtenaw; E. W. Blanchard, M.D., Sanilac; E. S. Carr, M.D., Chippewa-Mackinac; R. C. Conybeare, M.D., Berrien; C. C. Corkill, M.D., St. Joseph; Frank L. Doran, M.D., Kent; Ray M. Duffy, M.D., Livingston; F. Mansel Dunn, M.D., Ingham; L. Fernald Foster, M.D., Bay-Arenac-Iosco; C. L. Grant, M.D., Manistee; J. Bates Henderson, M.D., Huron; T. Y. Ho, M.D., Clinton; W. O. Jennings, M.D., Kalamazoo; Wm. S. Jones, M.D., Menominee; R. Bruce Macduff, M.D., Genesee; John J. McCann, M.D., Ionia-Montcalm; A. H. Miller, M.D., Delta-Schoolcraft; H. R. Moore, M.D., Newaygo; E. S. Parmenter, M.D., Alpena; G. B. Saltonstall, M.D., Northern Michigan; L. G. Sevener, M.D., Eaton; John C. Shoemaker, M.D., Tuscola; R. W. Spalding, M.D., Van Buren; Stanley A. Stealy, M.D., North Central; C. B. Toms, M.D., Luce; Arch Walls, M.D., Wayne; Herbert S. Wedel, M.D., Barry; Wm. Westrate, M.D., Ottawa.

Executive Secretaries included:

Wm. J. Burns, Lansing; Sara M. Burgess, Flint, and James A. Bechtel, Detroit.

Presidents of County Medical Societies who attended were:

Harold H. Gay, M.D., Midland; L. W. Hull, M.D., Wayne; C. P. Lathrop, M.D., Barry; Michael R. Murphy, M.D., Wexford.

MSMS officers who attended included:

E. F. Sladek, M.D., Chairman of The Council, and Councilors W. E. Barstow, M.D., Dean W. Myers, M.D., O. D. Stryker, M.D., C. E. Umphrey, M.D.

Editor W. B. Harm, M.D., of the *Detroit Medical News*, was present.

Others who attended included:

Congressman Bartel J. Jonkman, Grand Rapids; Prof. Floyd E. Armstrong, Mt. Pleasant; Prof. Paul D. Bagwell, E. Lansing; Lt. Governor Eugene C. Keyes, M.D., Dearborn; Auditor General Vernon J. Brown, Lansing; Mildred Busch, Lansing; Charles A. Coghlan, Detroit; H. Earle Correvant, Lansing; C. V. Costello, M.D., Holland; Carleton Dean, M.D., Lansing; Supt. of Public Instruction, Eugene B. Elliott; State Health Commissioner William DeKleine, M.D., Lansing; State Representative Andrew Bolt, Grand Rapids; L. W. Faust, M.D., Grand Rapids; N. K. Forster, M.D., Hammond, Indiana; President of Indiana State Medical Association; Perry W. Greene, Grand Rapids; Dr. Thomas G. Hull, Chicago; John D. Karel, Grand Rapids; Jay C. Ketchum, Detroit; G. L. McClellan, M.D., Detroit; W. B. McWilliams, M.D., Maple Rapids; R. L. Novy, M.D., Detroit; Katherine Post, Lansing; L. A. Potter, Lansing; Carl S. Ratigan, M.D., Dearborn; W. S. Reveno, M.D., Detroit; H. L. Sigler, M.D., Howell; Lillian R. Smith, M.D., Lansing; E. C. Texter, M.D., Detroit; R. V. Walker, M.D., Detroit; A. V. Wenger, M.D., Grand Rapids; G. E. Winter, M.D., Grand Rapids; F. J. Busch, M.D., Saginaw and L. J. Goulet, M.D., Ludington.

Woman's Auxiliary

OUR NEW PRESIDENT

The Woman's Auxiliary to the Michigan State Medical Society welcomes its new president, Mrs. Horace L. French of Lansing, Michigan.

MRS. H. L. FRENCH,

Mrs. French was born Lela Witter at West Branch, Michigan, May 11, 1902. She attended the University of Michigan 1918-22, receiving an A.B. degree with a major in mathematics. Her senior year she became a member of Phi Beta Kappa and Sigma Xi, national honorary societies. Following her graduation she taught mathematics in the Portland (Mich.) High School 1922-24, and the East Lansing High School 1924-25.

She is the wife of Horace L. French, M.D., also a University of Michigan graduate (1921) and a Fellow of the American Academy of Pediatrics. Their daughter, Carolyn, is a freshman at Michigan State College and son Lawrence (better known as Larry) a student at West Junior High School.

Mrs. French is a charter member of the Woman's Auxiliary to the Ingham County Medical Society (1926) and has served as secretary, treasurer, auditor, finance, welfare, and program chairman of that organization. In the state auxiliary she has been successively, secretary, treasurer, vice president and finance chairman, president-elect and finance chairman. Her other activities include membership in the St. Lawrence Hospital Auxiliary, Board of Directors of the Greater Lansing Visiting Nurse Association (president 1942-44), and the Lansing branch of the Board of Directors of the Michigan Children's Aid Society.

MABEL BOUGHNER, *Press Chairman*
(Mrs. Walter H. Boughner)

—— Subscribe to The Bulletin ——

THE PRESIDENT'S MESSAGE

The officers and chairmen of the Woman's Auxiliary to the Michigan State Medical Society for the year 1944-45 extend greetings and best wishes for a successful year to each county auxiliary and unaffiliated member.

The accomplishments of last year were outstanding, let us put forth every effort to maintain that record of achievement.

The same projects will again command the attention of the auxiliary. We will continue to aid in the recruitment of students for the United States Nurse Cadet Corps, and to explain to our friends, neighbors and clubs the basic reasons for the stand of the medical profession on proposed legislation. Cognizant of the importance of the following health projects we will co-operate with the Michigan Tuberculosis Association on the Radio Speech Contest and urge our members to participate in the work of the Women's Field Army.

Believing *Hygeia* an important aid in interpreting the ideals and aims of the medical profession to the public, we will make every effort to secure a wider distribution of this magazine. In addition we implore every member to interest herself in the problem of juvenile delinquency. Where there is a community group attempting the solution of this problem, offer your cooperation. Where there is no such group but a need for one, start its organization. Surely, auxiliary members can—and will—make a definite contribution toward eradicating this canker from American life.

Your officers and chairmen offer our assistance and will welcome any opportunity to be of service. With the continued efforts of each member the coming year can only show further evidence of the usefulness and value of the Woman's Auxiliary.

LELA W. FRENCH,
President

—— Subscribe to The Bulletin ——

ATTENTION COUNTY PRESIDENTS AND CHAIRMEN OF STANDING COMMITTEES

The Mid-year board meeting of the State Auxiliary is tentatively planned for the Monday following Thanksgiving in Detroit. Members will be notified of the exact time and place as soon as arrangements are completed.

County Presidents and Chairmen of Standing Committees are urged to submit plans for the coming year to Mrs. H. L. French, 1620 W. Main St., Lansing, Michigan, by November 5. These reports are the basis of Michigan's report, which Mrs. French will present at the National Conference of Presidents and Presidents-Elect to be held in Chicago, November 16 and 17.

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Both in independent laboratory tests and in careful clinical studies, Tampax tampons have been shown to possess a wide margin of safety in providing for intravaginal absorption of the flux.

Though variations, of course, occur in the amount of blood lost during the period—most women have been found to conform within relatively narrow departures from the average of 50 cc.[1].

Even *Junior Tampax* provides amply adequate protection—with its absorptive capacity of 20 cc. for *each tampon,* or 200 cc. for the period (10 tampons are usually considered an ordinary month's supply). In addition, *Regular Tampax* has a capacity of 30 cc., and *Super Tampax* 45 cc. for *each tampon* (or 300-450 cc. for the period).

In a recent study[2] of 110 young nurses employing Tampax tampons for catamenial protection, it was found that "95 per cent used tampons with satisfaction all through menstruation."

In another series[3], 18 (or 90%) of 21 subjects had "complete protection". Also "complete protection was afforded in 68 (94%) of 72 periods reported."

Other clinicians[4], investigating "twenty-five women under close institutional observation", noted that "with a tampon of proper size, absolute comfort and complete control of the flow can be obtained . . . the obvious advantage of the small, medium and large sized tampon of the particular brand (Tampax) is to be noted."

The results of this research parallel the experience of thousands of women who have found that Tampax affords thoroughly adequate protection.

(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

TAMPAX *accepted for advertising by the Journal of the American Medical Association*

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COUNTY AND PERSONAL ACTIVITIES

Wm. S. Reveno, M.D., Detroit, is the author of an original article, "Thyrotoxicosis Treated with Thiouracil," which appeared in the JAMA, September 16, 1944.

* * *

F. A. Rawling; M.D., of Ann Arbor is co-author of "Bronchial Asthma as a Manifestation of Sulfonamide Sensitivity" which also appeared in the same issue of JAMA.

* * *

Don H. Duffie, M.D., Central Lake, Michigan, has an article, "Hemoglobin Estimation by the Revolutionary Colorimetric Method," under Physical Notes and Suggestions of New Instruments, in JAMA of September 9.

* * *

Walter Brunk, a brother of President A. S. Brunk, M.D., and C. F. Brunk, M.D., of Detroit, died October 6 after a year's illness. The late Dr. Brunk was a practitioner of dentistry in Detroit. The Society's condolence is extended to the family of the late Dr. Brunk in their bereavement.

* * *

Paul D. Bagwell, Head of Speech Department at Michigan State College, addressed a panel at Central Methodist Church, Lansing, on October 25. His subject was "Report on the Michigan Survey of Public Opinion re Medicine."

* * *

The Michigan Society of Neurology and Psychiatry held its first regular meeting of the 1944-1945 season in Detroit on September 28. Dr. George H. Preston, Commissioner of Mental Hygiene for the State of Maryland, addressed the Society on the subject "Psychiatry and Demobilization."

* * *

"Implications of Nutrition and Public Health in the Postwar Period" was the subject of an all-day conference arranged by the Children's Fund of Michigan in Detroit on November 3. An excellent program was developed with ten speakers from various parts of United States and Canada. The medical profession was well represented at this conference.

* * *

The Michigan Pathological Society held its regular bi-monthly meeting in Grand Rapids on September 27, 1944, in conjunction with the meeting of the section on Radiology, Pathology and Anesthesia of the Michigan State Medical Society. A seminar on "Lesions of the Male Genital Tract" was conducted by Dr. Robert A.

(Continued from Page 1018)

(Continued from Page 1016)

Moore, Professor of Pathology, Washington University School of Medicine, St. Louis, Missouri. An afternoon session was held at the Pantlind Hotel at which 46 members and guests were present. Following dinner at the Blodgett Memorial Hospital, an evening session was held which was attended by forty members and guests.

* * *

EMIC Program Extended to One Year.—The emergency program for maternity and infant care for servicemen's families has been extended to include health supervision for their first year.

The care may be given either in the doctor's office or in child health conferences, depending on the operation of the state plan.

How much will be paid the doctor, how and when he can collect it, and such minor details are still somebody's secret.

* * *

The Wayne County Medical Society recently sent the following postal card to all its membership:

"Are you satisfied that present conditions will last forever?

"What do you think medical practice will be after the war? How about *your* practice?

"Do you know 'What's going on?' What are you doing about it?"

"This is a reminder of your Society's opening meeting next Monday night. It's a program you can't afford to miss."

* * *

A. S. Brunk, M.D., President of the Michigan State Medical Society, has been appointed by Governor Kelly to a Special Committee to study needs and resources of Michigan hospitals. The committee work will be financed by the W. K. Kellogg Foundation, the Commonwealth Foundation of New York and the National Foundation for Infantile Paralysis. Michigan and two other states will be surveyed as models for the rest of the nation. Other physicians appointed to the committee include: A. C. Furstenberg, M.D., Ann Arbor; E. W. Norris, M.D., Detroit; and Bruce H. Douglas, M.D., Detroit.

* * *

Radio broadcasts sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Chairman) during October were:

October 5—Dr. Jerome W. Conn, Associate Professor of Internal Medicine in the University of Michigan Medical School: Fat People and How They Get That Way.

October 12—Dr. Samuel W. Donaldson, Roentgenologist, St. Joseph's Mercy Hospital, Ann Arbor: The Role of X-Rays in Emergency Cases.

October 19—Dr. Julius M. Wallner, Assistant Professor of Psychiatry in the University of Michigan Medical School: The Patient.

October 26—Dr. James H. Maxwell, Associate Professor of Otolaryngology in the University of Michigan Medical School: Deafness.

(Continued on Page 1021)

(Continued from Page 1018)

Percy Jones General and Convalescent Hospital, Battle Creek, is sponsoring weekly staff conferences every Monday at 7:30 p.m. These programs, to which all members of the Michigan State Medical Society are invited, are held in the Officers' Conference Room. C. Howard Hatcher, M.D., Chicago, spoke on November 6; L. H. Newburgh, M.D., Ann Arbor, presented "Hyperglycemia in Obese Persons" on November 13. The dental service sponsored the program of November 20. Frederick A. Coller, M.D., Ann Arbor, will talk on "Treatment of Carcinoma of the Colon" on November 27.

* * *

Hopkins says socialized medicine not necessary.—Socialized medicine will not be necessary but public medical services must be made available to all income levels to keep Americans healthy in postwar years, Harry L. Hopkins, President Roosevelt's close friend and adviser, stated in a signed article in the November issue of *The American Magazine.*

In his article entitled "Your Job After the War," Mr. Hopkins, who frequently has reflected administration views, advances a formula for achieving prosperity and a higher standard of living and stresses the need for better housing facilities, education and health.

"Adequate medical care must be available to all income levels," he writes. "To work, men must be well. Sickness is a job-loser. The health of the American people can be improved through health insurance and increased public services. We do not need socialized medicine to do the job."

Mr. Hopkins does not elaborate on this particular subject. However, in his over-all plan for postwar prosperity he proposed reduced taxation, encouragement of small business and free enterprise, higher wages, broader social security benefits, preservation of the competitive system, and government spending only to supplement individual effort.

* * *

The Lapeer County Medical Society complimented David H. Burley, M.D., Almont, eighty-one years of age, and Henry G. Merz, M.D., of Lapeer, seventy-five years old, both of whom have completed more than fifty years of practice, and Frank A. Tinker, M.D., of Lapeer, eighty-five years old, who has been in practice sixty years. The testimonial banquet was held on August 29 at the Lapeer Country Club. President D. J. O'Brien, M.D., presided. H. B. Zemmer, M.D., toastmaster, introduced the three honor guests and also Councilor R. S. Morrish, M.D., Flint, MSMS Secretary L. Fernald Foster, M.D., Bay City, MSMS Past Presidents Herbert E. Randall, M.D., Flint, and P. R. Urmston, M.D., Bay City, and W. H. Marshall, M.D., Flint.

The three honor guests are still in active practice in their communities.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

SIMPLIFIED DIABETIC MANAGEMENT, By Joseph T. Beardwood, Jr., A.B., M.D., F.A.C.S. Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Physician to the Presbyterian Hospital in Philadelphia, and Herbert T. Kelly, M.D., F.A.C.S., Associate in Medicine, Graduate School of Medicine, University of Pennsylvania, Associate Physician, Presbyterian Hospital. Fourth edition. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944. Price $1.50.

Advances in insulin therapy, development of new forms of long-acting insulin, and food rationing in the war have made a new edition of this book necessary. Basically this book is for the patient, the diabetic, on the theory that with added knowledge he will be a better patient to handle. Also diabetes can now be treated in the home successfully. Theory and treatment are given as well as many tables of values to be used in arranging diet. A handy little book for both doctor and patient.

* * *

GLOBAL EPIDEMIOLOGY: A Geography of Diseases and Sanitation. By James Stevens Simmons, B.S., M.D., Ph.D., Dr. P.H., Sc.D., (Hon.), Brigadier General, U.S.A.: Chief Preventive Medicine Service, Office of the Surgeon General; Member National Research Council and Committee on Medical Research, O.S.R.D.; Tom F. Whayne, A.B., M.D., Lieut. Col. M.C., A.U.S., Formerly Director, Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon

General; Gaylord West Anderson, A.B., M.D., Dr.P.H., Lieut.-Col., M.C., A.U.S., Director Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon General, Harold Maclachlan Horack, B.S., M.D., Major, M.C., A.U.S. Chief Dissemination Branch, Medical Intelligence Division, Preventive Medicine Service, Office of the Surgeon General, and Collaborators. Vol. One. Philadelphia-London-Montreal: J. B. Lippincott Company, 1944. Price $7.50.

The Global War has made the infectious diseases of the whole world of primal importance to all of us. Our soldiers are being exposed to all such infections and are then coming home to bring the infectoin to us, or not, as we are being told. But to understand and to be prepared we must know what the exposures are. This book is devoted to India and the Far East, and to the Pacific Area. Each country and the major islands is given especial treatment. The articles are arranged alphabetically, and cover geography and climate, public health, health services, water supply, sewage disposal, insects and animals, medical facilities and institutions, and diseases. These are well written articles, quite complete. At the end of each subject is a summary and a group of references. Maps are given in explanation, and a well-arranged index. This book will find its place in the libraries of all institutions of health and education.

* * *

SEGMENTAL NEURALGIA IN PAINFUL SYNDROMES. By Bernard Judovich, B.S., M.D., Instructor in Neurology, Graduate School of Medicine, University of Pennsylvania: Clinical Instructor in Neurology, Woman's Medical College; Chief of Neurologia Clinics, Philadelphia General Hospital, Graduate Hospital and Woman's Medical College Hospital, Philadelphia, and William Bates, B.S., M.D., F.A.C.S.,

F.I.C.S., Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Foreword by Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania. 178 Illustrations. Philadelphia: F. A. Davis Company, 1944.

The diagnosis and treatment of painful neuralgias is beautifully outlined and illustrated in this book. Much attention is given to the diagnosis and the location of tender areas in the skin in arriving at conclusions. The treatment by injection is carefully described and illustrated in detail, so that technique should be easy to follow. A very worth-while treatise.

* * *

THE ART OF ANESTHESIA, By Paluel J. Flagg, M.D., Visiting Anaesthetist to Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, New York; Consulting Anaesthetist to the Woman's Hospital, Jamica Hospital, Mount Vernon Hospital, Flushing Hospital, St. Mary's Hospital, Far Rockaway, New York, Nassau Hospital, Long Island, Chairman of the Committee on Asphyxia of the American Medical Association. Seventh edition. 166 Illustrations. Philadelphia-London-Montreal: J. B. Lippincott Company, 1944. Price $6.00.

The history of anesthesia, the agents used, the effects on the patient are given extensive attention. The physiology of anesthesia is studied. A chapter is given to the signs of anesthesia. Ether, ethyl chloride, chloroform, nitrous oxide, nitrous oxide-oxygen, nitrous oxide-oxygen-ether, and ethylene are all studied in detail with a thought to the teaching of good anesthesia. Local anesthesia and regional block anesthesia are detailed. The second part of the book is devoted to study of preliminary and postoperative medication, pre-anesthetic examination, the viewpoint of the patient, selection of

methods and anesthetics, and many more topics important to the well-trained anesthetist. This book is a standard, well illustrated, printed in easily read type, and a good sample of the bookmaker's art.

* * *

CANCER: A MANUAL FOR PHYSICIANS. Published jointly by Michigan State Medical Society and Michigan Department of Health. Cloth. Pp. 225. Lansing, 1944.

This book is written by members of the Michigan State Medical Society under the editorship of its cancer committee. The Michigan Department of Health contributed toward the expenses of publication. Like that of similar books in other states, its purpose is to "assist the physician in making his diagnosis of early cancer and in reaching his decision as to the type of therapy to be employed, without subjecting the patient to the dangerous delay that sometimes occurs." There are forty-four unsigned articles by thirty-eight authors. These articles deal with the general and special aspects of cancer, including tumors of the brain and of bones. The articles are of course short but as a rule cover their topics well. The articles on biopsy in tumor diagnosis and on radiotherapy of cancer are especially praiseworthy. The statement about grading of cancer in the first of these articles merits quotation: "Many physicians attach far too much importance to the numerical grade of neoplasms. It must be kept in mind that the grade is assigned by the pathologist only in accordance with his impression of the level of differentiation. By itself, the grade tells nothing about

the clinical state of the patient, nor does it indicate the prognosis. A grade 1 carcinoma may have been present for many years and may have spread widely by both infiltration and metastasis. It may still be grade 1 when the patient is about to die from its effects. Conversely, a grade 4 carcinoma may be so early and so small that the patient can be cured by a single sweep of a curet. Type of neoplasm, location, extent, duration and metastasis, as well as grade, determine the prognosis." It may be mentioned also that the fundamental principles of treatment remain the same whatever the grade. The article on carcinoma of the larynx is utterly inadequate, because it does not even mention its treatment with external radiation, which is now the treatment of choice of certain forms of laryngeal cancer. There are instructive articles on occupational cancer, on tumors of the endocrine glands, on the care of the patient with advanced cancer, on the Michigan program, on lay education and on cancer from the general practitioner's point of view. "The most worth-while service the general practitioner can render his patients who may have cancer is in prompt initiation of the processes through which they will obtain the best diagnostic and therapeutic services possible."—Review in J.A.M.A., Sept. 23, 1944.

* * *

DR. COLWELL'S DAILY LOG FOR PHYSICIANS. A Brief, Simple, Accurate Financial Record for the physician's desk. Champaign, Illinois: Colwell Publishing Company, Not Inc. 1945. Price $6.00.

ECHOES OF THE 1944 WAR CONFERENCE

(Continued from Page 954)

M.D., who was taken ill with pneumonia a few days before the MSMS Annual Session.

* * *

Butterworth Hospital, Grand Rapids, sponsored a Scientific Exhibit on "Hip Fractures" at the 79th Annual Session of the Michigan State Medical Society in the Civic Auditorium, Grand Rapids, the week of September 25.

* * *

The Little Traverse Hospital of Petoskey sponsored a Scientilc Exhibit on the "Photometer."

* * *

ARTHUR M. HUME HONORED

As a testimonial to Arthur M. Hume, M.D., of Owosso, the oldest living Past President of the Michigan State Medical Society, the Shiawassee County Medical Society sponsored a banquet in Grand Rapids on the occasion of the MSMS Annual Session. All the living Past Presidents of the Michigan State Medical Society, as well as members of the Shiawassee County Medical Society, were invited.

Among the distinguished guests who honored Dr. Hume were: Herbert E. Randall, M.D., Flint (President 1927-28), J. D. Brook, M.D., Grandville (President 1929-30), Henry Cook, M. D., Flint (President 1937-38), Henry A. Luce, M.D., Detroit (President 1938-39), Paul R. Urmston, M.D., Bay City (President 1940-41).

Telegrams of congratulations to Dr. Hume were received from J. B. Jackson, M.D., Kalamazoo (President 1926-27), Louis J. Hirschman, M.D., Detroit (President 1928-29), J. Milton Robb, M.D., Detroit (President 1932-33), Col. Grover C. Penberthy, Omaha, Nebraska (President 1935-36), and H. H. Cummings, M.D., Ann Arbor (President 1942-43).

The welcome was given by C. L. Weston, M.D., of Owosso. The biography of Dr. Hume was read by A. L. Arnold, Sr., M.D., Owosso, the oldest member of the Shiawassee County Medical Society.

A book of congratulatory letters and other mementos of the occasion was presented to Dr. Hume.

R. C. Pochert, M.D., of Owosso, president of the Shiawassee County Medical Society, organized the meeting which was held in the Pantlind Hotel on September 27, 1944.

INDEX TO ADVERTISERS

THE JOURNAL

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Unretouched photo of refrigerator car being loaded with Penicillin-C.S.C.

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WAR MEDICINE

ARMY ENDS ITS DOCTOR "DRAFT," NAVY'S GOES ON

Washington, D. C., Oct. 31—The War Department announced through the War Manpower Commission today that recruiting of civilian physicians for the army has been discontinued. WMC Chairman McNutt said, however, that recruiting for the Navy must continue because of an urgent need of approximately 3,000 more medical officers.

Other Agencies Seeking Doctors

The public health service of the federal security agency and the veterans' administration also are continuing to seek physicians.

McNutt disclosed he has been informed by the War Department that the Army will fill its future requirements for military physicians from sources now available, such as students and graduates of the Army specialized training program and a small number of individuals whose commissions are being processed. Accordingly, the Army no longer will require certification of availability of additional physicians from the WMC's procurement and assignment service.

McNutt reported that there are roughly 60,000 physicians in the Army, Navy, and the veterans' administration, a total representing about 40 per cent of the active medical profession in the United States.

"Grave Shortage" in Pacific

Vice Adm. Ross T. McIntire, chief of the Navy's bureau of medicine and surgery, informed McNutt that personnel expansion and intensification of Pacific operations have resulted in a "grave" shortage of medical officers.

With less than 13,000 medical officers in active duty in the Navy, the procurement of at least 3,000 more as soon as possible is imperative, Adm. McIntire said. Even this figure will not meet actual needs.—*Chicago Tribune Press Service.*

DOCTOR SHORTAGE PAYS OFF

In the past, when great battles were fought, loss of life was multiplied tenfold because of lack of prompt and adequate medical care for the wounded. But in the present war the story has been different. Even yet the full account of the achievements of medicine on "D-Day" has not been impressed upon the country.

One correspondent reports that within 45 minutes after the first troops landed on the shores of France, a medical unit was on the beachhead picking up casualties, while in the background a landing craft had been converted into an operating theater.

During the first day, twenty-two major operations were performed by this single unit. From dawn on "D-Day" until four o'clock in the afternoon, the unit remained on the beach. Blood plasma had been landed and transfusions made from mobile equipment.

Fifty thousand American doctors are in the armed forces. Every one of them is a trained expert at the business of saving lives. At least those civilians who had had to linger in crowded waiting rooms to secure the attention of the overworked doctors on the home front, can see the reason for the inconvenience thrust upon them—*Chickasha Star,* Sept. 21, 1944, quoted by the *Journal of the Oklahoma State Medical Association.*

PROGRESS IN CHEST SURGERY

Military surgeons are focusing attention on restoration of full lung function rather than the mere prevention of empyema in chest wounds—an important advance in thoracic surgery which is reflected in the surprisingly high number of chest cases returned to duty in the Italian campaign.

Out of 320 men admitted to one general hospital with penetrating chest wounds, 225 either returned to duty or were prevented from doing so by other injuries. Only fifty-four developed empyema. Of these, it was felt that five might require further surgery. And only two deaths in the group were directly attributable to chest wounds.

SEPARATIONS FROM MILITARY SERVICE

If any MSMS member knows of any Michigan physician in military service who has recently received an honorable discharge and is now back in this state, the State Society would appreciate receiving the name of the doctor so that he may be contacted and told of the opportunities available to him in connection with the medical Veterans' Readjustment Program, created by the MSMS House of Delegates at its 1944 session (see President's Page). Send names to the Readjustment Program Committee, 2020 Olds Tower, Lansing 8, Michigan.

IMPORTANT TO DOCTORS RETURNING FROM MEDICAL CORPS SERVICE

Doctors discharged from military service and returning to private (civilian) practice should give attention to the conversion of "Military Service" professional liability insurance policies to private or civilian practice coverage. Promptly notify your insuring company so that any adjustment indicated may be effected. "Military Service" policies do not cover professional liability in civilian practice (unless specific provision is made in individual contracts). Be on the safe side and convert at once to private practice coverage.

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● ***The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.***

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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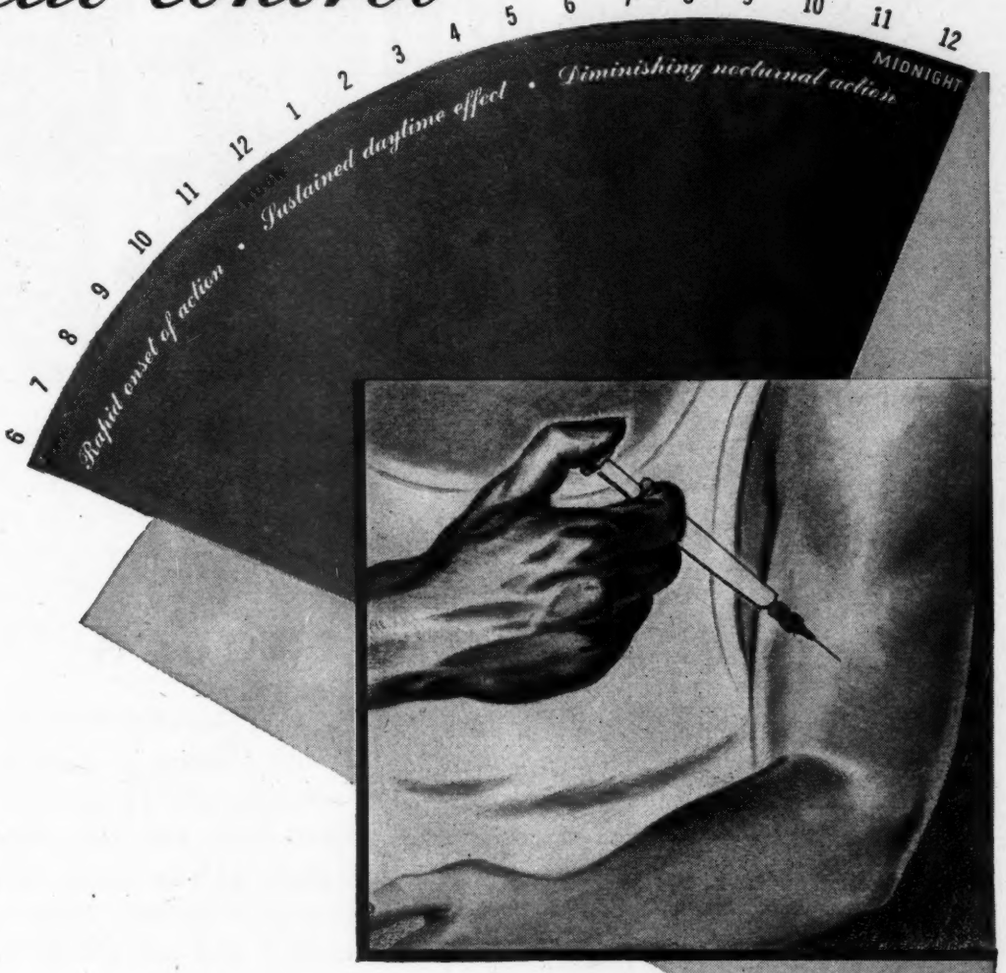

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'Wellcome' Globin Insulin with Zinc is a clear solution and, in its freedom from allergenic properties, is comparable to regular insulin. It is accepted by the Council on Pharmacy and Chemistry, American Medical Association, and was developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Pat. No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. 'Wellcome' Trademark Registered

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MAY NOT BE ENOUGH

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A food supplement in the literal sense of the word, Ovaltine is a balanced mixture of nutrients, which provides virtually all the metabolic essentials. When taken twice daily with the average diet, Ovaltine makes good the deficiencies usually encountered, and converts the total daily intake to nutritionally satisfying levels. The easy digestibility of this delicious food drink is an added advantage.

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CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
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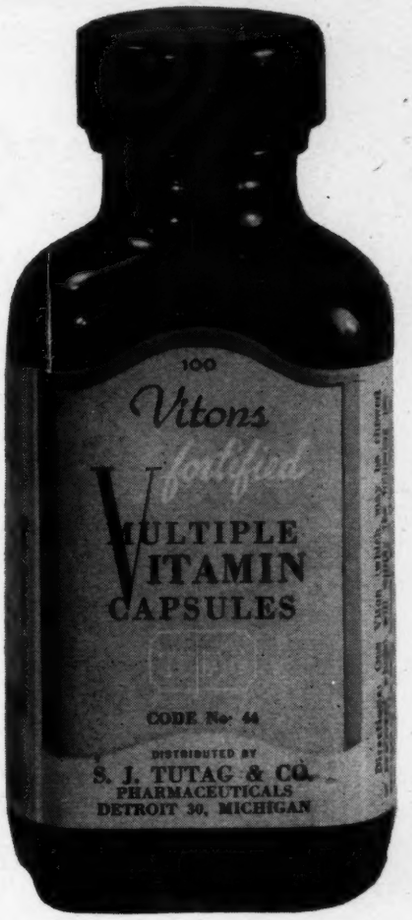

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Vitamin B1 (Thiamin Chloride USP) 1500 USP units.. 4.5 milligrams

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Paredrine-Sulfathiazol

How It Shortens the Course of Infection and Helps Avert Sequelae to Colds

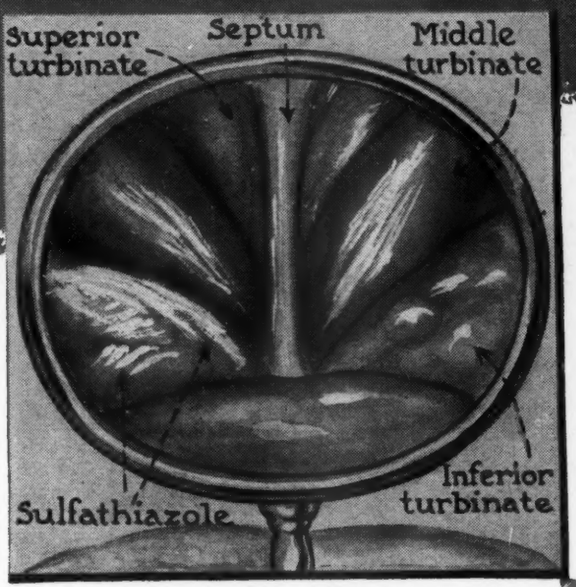
THESE drawings—from photographs presented as a scientific exhibit at the 1944 Meeting of the American Academy of Ophthalmology and Otolaryngology—demonstrate why Paredrine-Sulfathiazole Suspension is so strikingly effective in nasal and sinus infections. The choanae of patient T. D.—with subacute pansinusitis—are illustrated.

The dramatic success of Paredrine-Sulfathiazole Suspension in aborting colds and averting complications is largely due to its prolonged bacteriostatic action. When the Suspension is administered on retiring, for example, sulfathiazole can often be observed on infected mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for this prolonged bacteriostatic action is the fact that Paredrine-Sulfathiazole Suspension—not a solution, but *a suspension* of free sulfathiazole—covers the nasal mucosa with a fine, even frosting of sulfathiazole, which does not quickly wash away. Yet the Suspension does not cake or clump, and does not interfere with normal ciliary action.

SMITH, KLINE & FRENCH LABORATORIES
VASOCONSTRICTOR-SULFONAMIDE

Suspension—

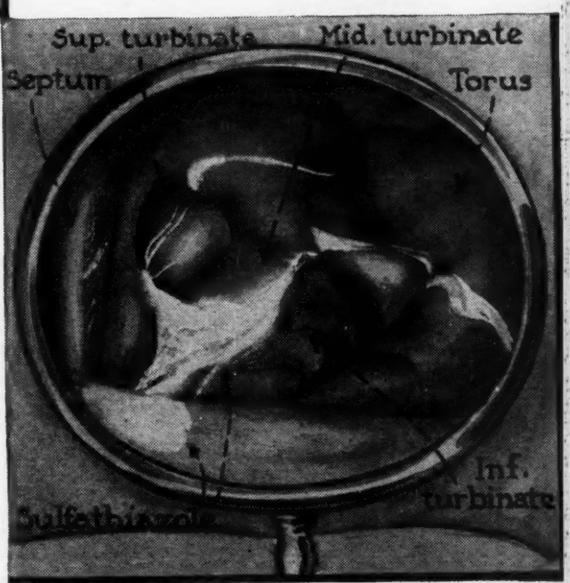


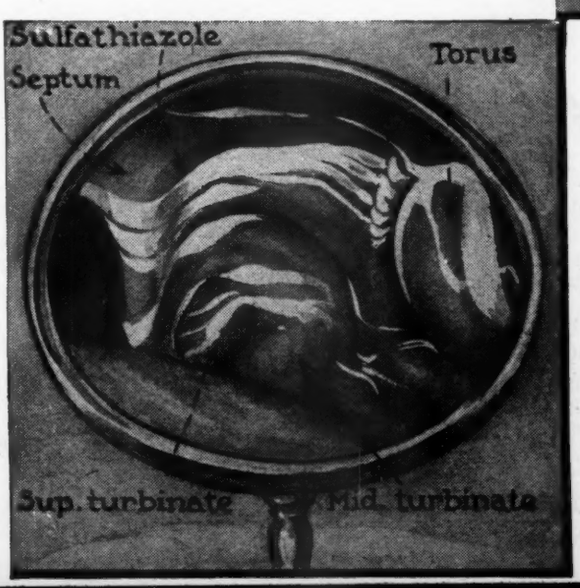
⬅ 30 MINUTES AFTER INSTILLATION

The Suspension has been swept onto infected areas, where ciliary action is impaired. The sulfathiazole remains on infected areas and keeps producing a bacteriostatic solution.

45 MINUTES AFTER INSTILLATION ➡

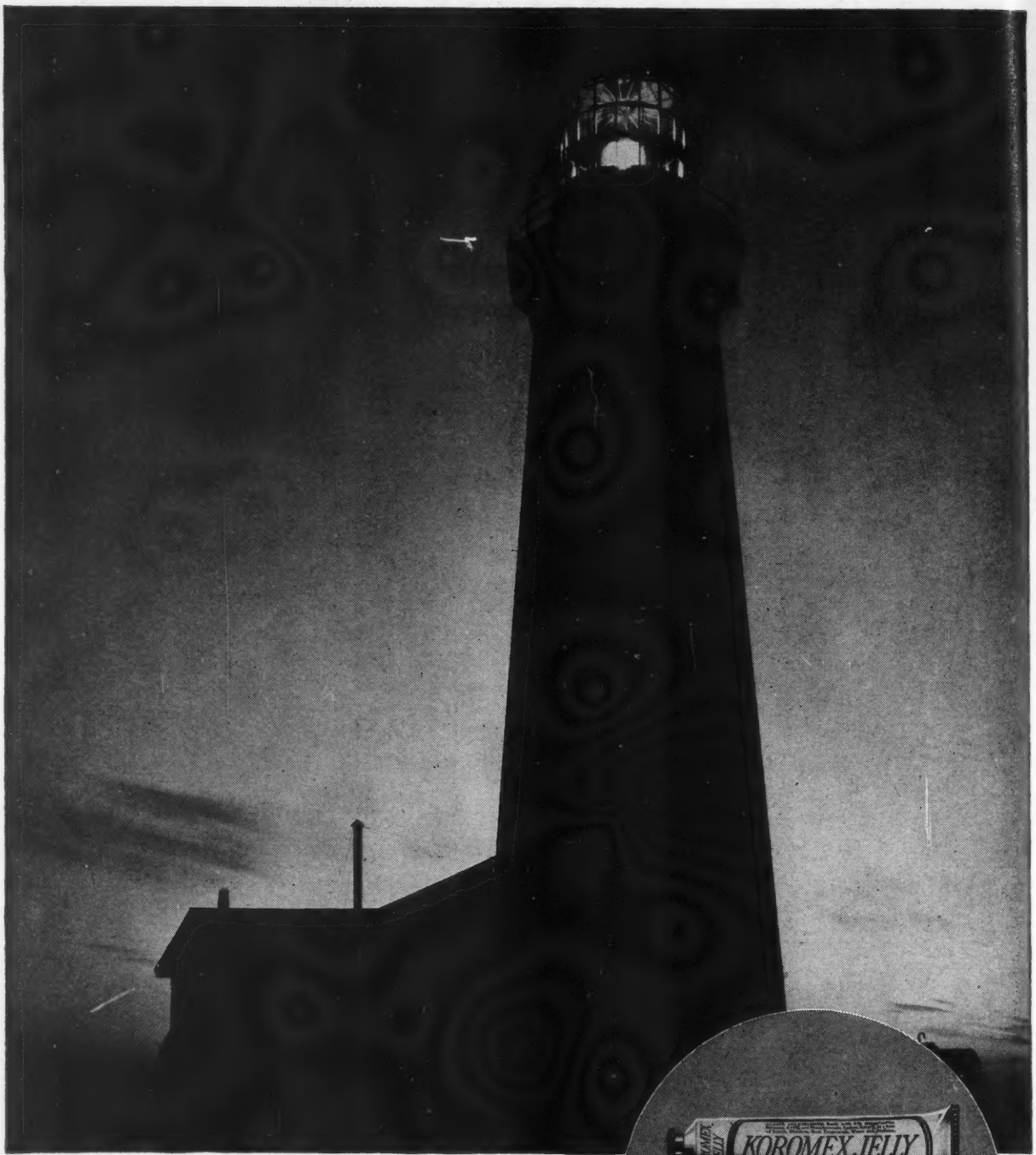
Sulfathiazole mixed with pus is passing over the orifice of the Eustachian tube. Should pus enter the middle ear, the sulfathiazole will minimize the likelihood of otitis media.





⬅ 50 MINUTES AFTER INSTILLATION

Sulfathiazole is streaming beneath the turbinates where it mixes with pus draining from the sinuses. Thus, the Suspension helps prevent the incidence of nasopharyngitis, pharyngitis, etc.



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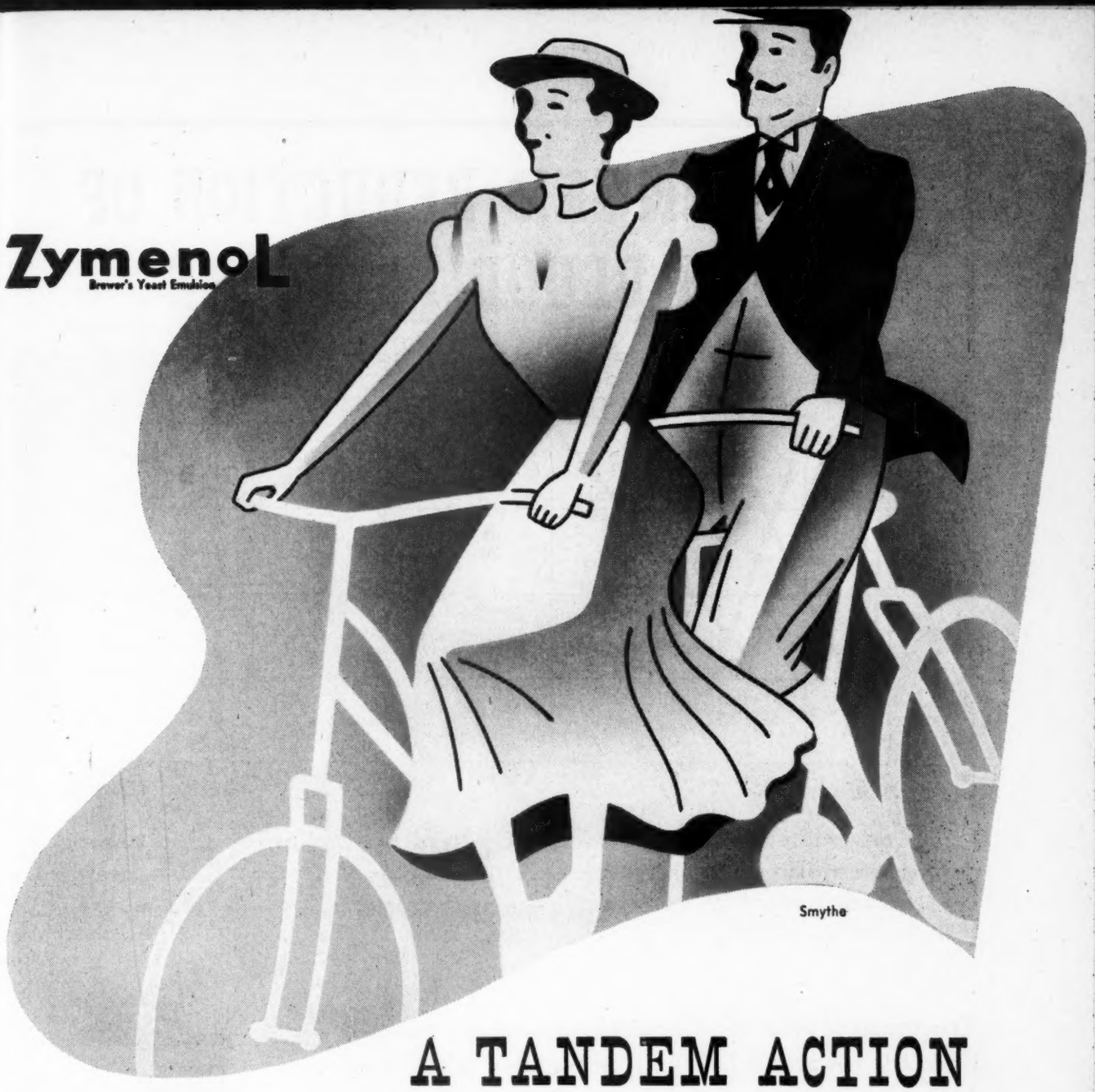

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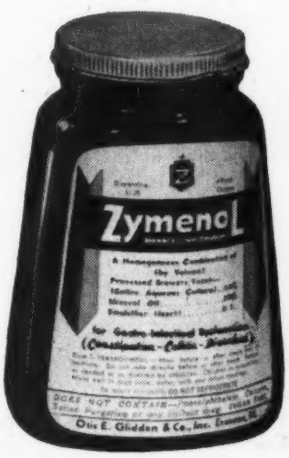

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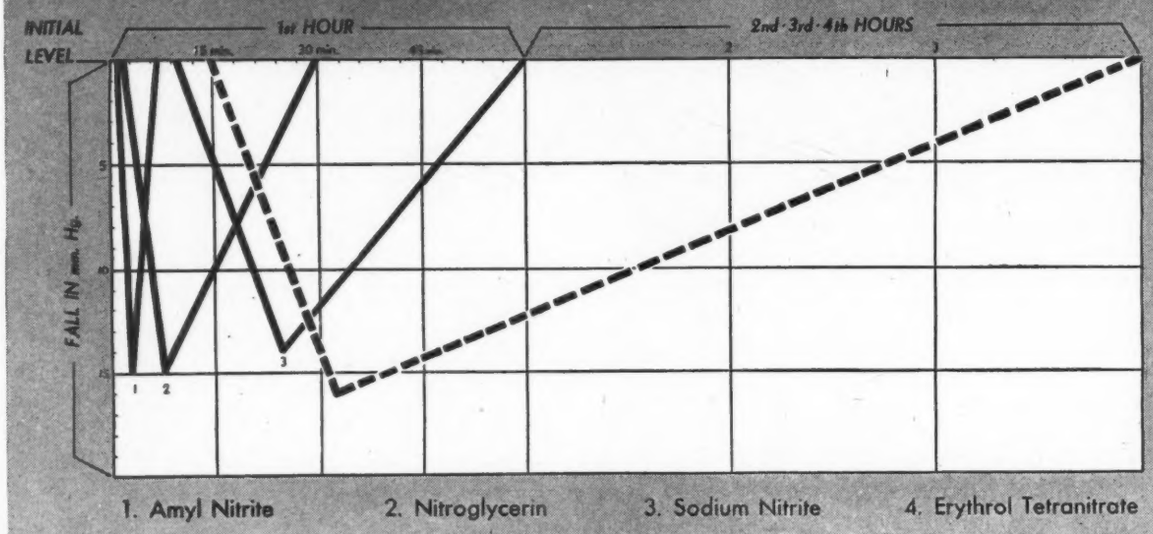

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Treatment of arterial hypertension today is necessarily directed toward relief and not cure. When such measures as rest and dietary control have been unsuccessful, the employment of medical treatment is suggested. Among the various preparations available, Erythrol Tetranitrate offers the advantage of producing a reduction in blood pressure sufficiently prolonged so that administration three times daily may maintain the reduction. Erythrol Tetranitrate Merck may be prescribed over a protracted period with sustained effect. By dilating the peripheral arterioles, it tends to decrease not only the stress of excessive pressure on the arterial walls, but also to relieve the burden of the heart.

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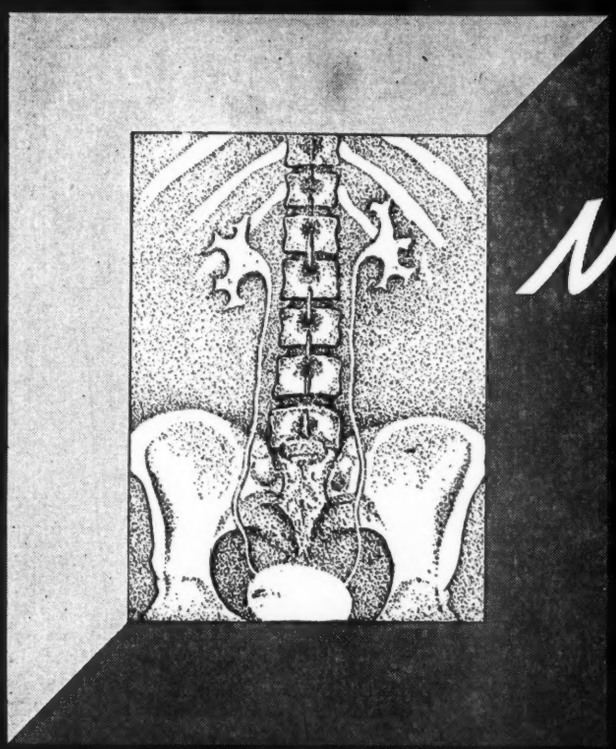

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